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ABSTRACT

Initially published by the Children's Bureau in 1913, this pamphlet has been revised frequently. Its purpose is to point out the importance of medical care during pregnancy. Comfortable pregnancies, easy labor, and better care for their new infants are the usual concerns of prospective mothers. Consequently, this 1962 edition of "Prenatal Care" tells parents about the succeeding stages of pregnancy, about childbirth and the care of the newborn, and also shows how each family member can share in the preparation for the baby. Suggestions include how to arrange for medical and hospital care, and helpful advice is proffered concerning nutrition, exercise, and personal hygiene. (DP)

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PRENATAL CARE was first published by the Children's Bureau in 1913. This is the first time, however, that it has been issued by the Office of Child Development, to which the Children's Bureau has been transferred. Through the years, the chief aim of this pamphlet has been to point out the importance of medical care during pregnancy. Early editions stressed the care an expectant mother should receive before her baby was born:

Great advances have been made in our knowledge about pregnancy, childbirth, and infant care. This increased knowledge makes having a baby safer today by far than ever before.

Our concept of good care for the mother and her baby has broadened considerably in recent years. Indeed, in one sense, it begins even before conception. The good health the mother has built during her childhood years helps to prepare her for having a healthy baby. Once the baby is on the way, "maternity care" includes health supervision from early pregnancy through the birth of the baby and for several weeks after. Comfortable pregnancies for mothers, easy labor, and better care for their new infants are the concern of this pamphlet.

Every pregnancy involves the entire family in many ways. Consequently, this pamphlet not only tells parents about the succeeding stages of pregnancy, about childbirth and the care of the newborn, but also shows that each family member shares in the preparations for the coming of the baby.

This 1962 edition of this pamphlet was written by Muriel W. Brown, Specialist in Parent Education, Division of Research, under the direction of Dr. Marian M. Crane, Assistant Director, Division of Research, and with obstetric guidance from Dr. Robert E. L. Nesbitt, Jr., Professor and Chairman, Department of Obstetrics and Gynecology, Albany Medical College of Union University, Albany, New York. Many helpful suggestions were also received from other members of the Children's Bureau staff. Sincere thanks are due to the many obstetricians, pediatricians, other professional people, and parents who reviewed the manuscript. The illustrations are the work of Edythe Alpert, Division of Reports.

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What this pamphlet is about

IF you are expecting a baby, this pamphlet was written for you and your husband. You may be pregnant for the first time, or you may have other children. In either case, you will have questions because, even for experienced mothers, every pregnancy is different. We hope that this pamphlet will help you and the baby's father to answer some of these questions for yourselves. It is based on the belief that having a baby is normally a happy, satisfying experience, safer today by far than ever before.

In spite of differences in family situations, all babies have at least one thing in common. Each one spends the first few months of his life in a special kind of relationship with his mother. It is she who keeps him warm and safe within her body and gives him the nourishment he needs in order to grow. This means that many of the things you will want to know about your pregnancy will have to do with your baby's development and what you can do for him before he is born.

As the weeks pass and you begin to think more and more about the baby as a person in his own right, you will want to know more in detail about what is happening to him and to you. In this pamphlet, you will find reliable information about pregnancy and infant development. You will also find suggestions about arrangements to be made for medical and hospital care, about preparations for the baby, about your own nutrition, exercise, and personal hygiene.

You will also find in this booklet a section about feelings that are common in pregnancy. No matter how pleased you are about the baby, there may be times when you feel discouraged. If your spirits do go down occasionally it may cheer you to know why expectant mothers are sometimes depressed, and how these moods can often be managed, especially if husbands and other family members understand how to help.

If you and your husband have not been married long, you and he are probably just getting to know each other. A new baby will make demands on both of you that you may not have expected. How will you meet them? In this age of science, a great deal of information is coming from the study of family life. Some of this knowledge you will surely want to have because it will help you to foresee and prepare for some of the situations that naturally arise when a family grows by taking in a new member. Some of this information about family development you will find in this pamphlet. Solving problems in family relationships is like any other kind of problem solving—a way of meeting life. Most people who have learned how to use it, find it a very good way indeed.

Because every pregnancy *is* different, no one can tell you in advance, exactly what yours will be like. It is good to know, however, that modern medical science has gone far toward controlling

conditions which sometimes used to worry expectant parents.

The making of a good plan for prenatal care requires many decisions. When should you first see a doctor? What kind of medical and nursing care will you need? Where will your baby be born? Who will help you at home before and after the baby comes?—your mother? your mother-in-law? some other relative? a friend? a housekeeper? What supplies and equipment for the care of the baby will you need to provide ahead of time? How will you get these things?—buy them? rent them? What arrangements for meeting expenses should you make in advance?

These are the kinds of questions that come up in the course of every pregnancy. Your doctor will want you to feel free to ask him anything you would like to know. He will give you as much of his time as he can, because your peace of mind is just as important to him as it is to you. He may also refer you to other people and agencies in your community for further instruction and guidance.

Having a child is a normal and good experience, an achievement for which a woman's whole being prepares her from the moment of her own birth. To you and your husband, your pregnancy may seem like a very private and personal matter. Actually, there are few things that more people are concerned about than the health and happiness of babies and their families.

The priority you have, as an expectant mother, in buses, stores, on the street, and in other public places is evidence of this concern. So are the educational programs and the health and welfare services provided for expectant parents by different public agencies and private organizations in your community. This pamphlet will have accomplished one of its main purposes if it helps you to use all the resources within your reach to make the coming of your baby a truly rewarding experience for you and your family.

Your medical care

The beginnings of prenatal care

You are having your baby at a time when more is known than ever before about pregnancy, childbirth, and infant care. This increasing knowledge is changing some of our older ideas about prenatal care and proving the values of others.

Prenatal care, as we know it today, begins even before conception. All the good health habits you have learned while you were growing up have helped

to prepare you for the experience of having a baby. Your good health, now, is insurance for you and your child.

It is wise to see your doctor for a general health examination before you become pregnant. This gives him information about you and your health that he can use to great advantage when your pregnancy begins. He will certainly want you to come to him as soon as you are reasonably sure that conception has taken place.

There is no way of telling exactly when conception does occur but there are some early signs of pregnancy. You will recognize these if you have had a baby before. The first of these is usually the absence of a regular menstrual period, although this is not always a sure sign. Menstruation can be delayed for other reasons. Some pregnant women even have a small flow at the regular time during the first three or four months.

When a baby has actually started to develop, he soon manages to make his presence known. You may be sleepier than usual. Your breasts may begin to enlarge and become tender. You may need to urinate more often. You may be slightly nauseated in the morning or even later in the day, especially if tired or upset.

If you have skipped a period and have any of these other symptoms, it is important for you to see a doctor. Whoever takes care of you will need as much time as he can have, before the baby comes, to get to know you, and to work out with you a plan for your care that will meet your own personal needs and your particular family situation.

There are special laboratory tests for pregnancy, as you may have heard. If your doctor thinks it is advisable for you to have one of them, he will make the arrangements for you. Most people do not bother with these unless there is an urgent reason for an early diagnosis.

Arranging for medical supervision

Once you are sure that you are pregnant, you will naturally begin to make plans. Wherever you live, however you live, whatever your income may be, there are things you can do, and services you can use to safeguard your health and your baby's.

Since prenatal medical supervision is the key to successful childbearing, your first step should be to arrange for this. It is given by private physicians, and by doctors in hospital clinics, public health centers, and private health organizations. If you have a tight budget, try to find out what maternity care is available in your community, at a price you can afford. You can get this information from your health department or from a local hospital.

If there is a public health nurse in your town or county, she may be your chief adviser, especially if you are getting your prenatal care through a public health clinic. She will be able to tell you about health and welfare services for which you may be eligible, and to make other suggestions that may help you solve any problems you may have.

If you have a family doctor, your prenatal care has already begun. Through the health care he has been giving you, he has already contributed a great deal to the success of your pregnancy. Physicians in general practice have included obstetrics (maternity care) in their training. Your regular doctor will decide whether to refer you to an obstetrician or look after you himself. Later, you may want him to take care of your baby. Or, he and your obstetrician may prefer to help you select a pediatrician. Whatever the arrangement, make it early, so that a physician can help you in planning for the care of the baby and will be ready to begin your child's medical supervision as soon as he is born.

Perhaps you are a newcomer in your community. Friends may be able to recommend a doctor, but it is wise to have professional advice about this, too. Call the office of your local medical society or ask at the nearest hospital, public health center, social service agency, or nursing organization for the names of two or three good family doctors in your neighborhood. At the same time, you might also ask about obstetricians.

Your first examinations

When you have chosen a doctor, go to him as soon as you can for your first examination as an expectant mother. It is highly desirable for your husband to go with you if he can. Whether you go to a private doctor or to a public clinic for this, you will need to make an appointment in advance. When you call for this, ask if the first visit will be long or short. It is always well to be prepared for a longer absence from home than you expect. One appointment may include a number of different examinations which may take, altogether, several hours. If you have small children try to leave them at home or with relatives or friends. When you have to take a little child with you, take along a storybook or one of his favorite small toys. Find out whether there is a snack bar or cafeteria where you can buy sandwiches, milk or juice. If not, bring some light refreshment with you. Children become irritable when they are hungry and tired, and so do their mothers.

Wherever your first examination takes place, about the same things will happen. Someone in the doctor's office will begin your record by making out a card with your name, address, telephone number, age and place of birth; the name, age, birthplace, occupation and business address of the baby's father; the names and ages of any other children you may have. When the doctor, himself, sees you for the first time, he will probably go more fully into your own history and your family history. He will be particularly interested in any previous pregnancies, including any miscarriages you may have had. He will ask about your menstruation: how old you were when it began, how regular it is, and whether or not it gives you any trouble. He will also want

you and your husband make your first visit to the doctor

to know about previous illnesses, or serious accidents. If you have family problems, tell him about these. He needs all the information he can get about you in order to help you with real understanding.

After this history has been taken, you will be shown into a dressing room or into the doctor's examining room and left to undress. The nurse will give you a sheet or robe to wrap around you. You may have been told in advance to bring a sample of urine. If not, you will now be asked to urinate into a container which the nurse will give you. This specimen can give the doctor valuable information about your health and he will have it analyzed as soon as possible. This test will be repeated at regular intervals until after your baby is born.

Your first examination is likely to be very thorough. You will be weighed and your height will be measured. The doctor will take your blood pressure, test your reflexes, note the color and texture of your skin. He will check your eyes, ears, nose, throat, and teeth for any signs of conditions that may need attention. He will examine your breasts to see if they are tender, or if there is any secretion from the nipples. He will thump your chest, listen to your heart and lungs with a stethoscope, and examine your abdomen.

Next comes the internal or pelvic examination. Try to relax completely for this. Breathing through your mouth will help. The doctor places a tube-like instrument (speculum) in the vagina, the passageway to the uterus. This opens the vagina a little so that, with a light, the doctor can see the mouth of the uterus (cervix). During this examination, he may wipe off the lip of the cervix with a cotton-tipped swab. This will give him a few cells to have tested to rule out the possibility of cancer.

After removing the speculum, the doctor then puts two gloved fingers into the vagina and his other hand on top of your abdomen. In this way, he can feel the uterus and learn about its size, shape, and position. This and the other tests he makes will give him a good idea of how far along your pregnancy is.

While he is making this internal examination, your doctor may take certain measurements to determine the size of your birth canal. These measurements may be postponed until a later visit but they are always made sometime during a pregnancy. Later on, the doctor may want to use X-rays to make sure that the bony structure of the birth canal is large enough for a normal birth.

Doctors know that in the very early months of development, a baby is more sensitive to X-rays than he will be later. They, therefore, make it a general rule to X-ray the abdomen only when it is important to have information that can be obtained in no other way. This is why an abdominal X-ray is usually postponed until the latter part of pregnancy.

X-rays of the chest, head, legs or arms can do no harm to even an early pregnancy, when carefully carried out. From the time you first suspect that you are going to have a baby, be sure to tell any doctor who advises an X-ray for you that you are or may be pregnant. He can then decide whether or not to go ahead with the X-ray at that time.

Early in your pregnancy, perhaps during your first visit to your physician, a little blood will be taken from one of your arm veins with a needle. This blood will be used for several tests: one for anemia, one for syphilis, one to find out what your blood type is and to check for the Rh factor. (See p. 58.)

When these examinations are over, the doctor or the nurse will want to talk with you about the general care of your health during your pregnancy: your food, your rest and sleep, your weight, the care of your teeth, your clothing, your work, exercise and recreation. This will be a good time for you and your husband to

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bring up such questions as: Should we have marital relations during the pregnancy? When will the baby be born? Where? What will the charges be, and for what services?

Marital relations

Without much evidence to support it, there is a rather widespread belief that intercourse during the times when you would have had your second and third menstrual periods following conception may make a miscarriage more likely. Although this may not be true, it does no harm to be on the extra-safe side. Your doctor may, therefore, advise you not to have marital relations during those days. He may, also, recommend that, about two months before the baby is due, you stop having marital relations altogether. This is a wise precaution because there is a possibility that germs always present on the skin may be carried up to the uterus during intercourse.

The due date

When will your baby be born? In the human being, the average time from conception to birth is about 266 days. Since it is so nearly impossible to know when conception has occurred, doctors have had to find a way of estimating the due date that does not depend on this. Relying on the fact that most babies are born about 280 days after the beginning of the mother's last normal menstrual period, they usually count back 3 months from the first day of the last normal menstruation and add 7 days. For example, if your last period started on June 10, your baby will arrive about March 17, according to this formula. Only about 1 in 12 babies arrives exactly on the day indicated, so don't be alarmed if your labor begins one or two weeks earlier or later than you think it should.

the best budgets are made in advance

Hospital arrangements

Where will your baby be born? At a first appointment, the doctor or the nurse may not have much time to tell you about hospital arrangements. If you are a patient at a hospital clinic, you will probably be having your baby in this hospital. A private physician may be able to give you a choice of several hospitals. Make an early selection, if you have a choice, so that you will have plenty of time to become familiar with the hospital where you will be, and its requirements. See page 36 for information about hospitals and the provisions they usually make for maternity care.

Medical fees for maternity care

You will want to ask your doctor not only what his total charge will be, but what this includes. Is he giving you a flat figure that covers everything, or will there be separate charges for laboratory tests, X-rays if these are needed, drugs, the services of an anesthetist?

Be frank with your physician. If you find you have come to a doctor you cannot afford, ask to be put in touch with services you can afford. This does not mean that your care will be inferior. It does mean that you will not be worrying about how your bills are going to be paid. Above all, don't stay away from a doctor you want just because you have heard that he is expensive. Many physicians adjust their fees to their patients' incomes.

Natural childbirth

Many women are interested in an approach to childbearing called natural childbirth. This is a name given to a special kind of maternity care which originated in England some time ago. You may be one of the mothers who has previously had a child by this plan. On the other hand, you may have heard just enough about it to want more information. Your doctor will be glad to tell you whatever you wish to know.

Briefly, it is a program of education, exercise, and training which prepares a woman, mentally and physically, for active and conscious cooperation with the processes of birth during labor and delivery. Under the supervision of doctors and nurses especially trained to help her do this, an expectant mother learns how to relax and work in harmony with the forces that bring her baby out of her body into the world. Because she receives little or no medication, there is little or no anesthesia in her system for her baby to absorb.

Every doctor who delivers a baby wants the birth to be as natural and satisfying an experience for the mother as possible. What is "natural" for one person, however, may not be for another. Your doctor will try to work out, with you, a way of handling your pregnancy, labor, and delivery that will seem right to both of you. If he wants you to take certain exercises, he will show you how to do them, or refer you to a class where they are taught by a nurse with special training for giving this instruction. He may also suggest that you join a group or class for expectant parents sponsored by your hospital, a public health agency, the American Red Cross, a nursing association or some other medically approved agency.

Other appointments

Arrangements will be made for later visits at the time of your first appointment with your doctor. Ordinarily, he will want to see you once a month through the first six months, and more often after that.

Make every effort to keep all of your appointments. Every one is important. Each time you see him, your doctor will want to check on your weight and your blood pressure, examine your abdomen to see how much the baby has grown and what his position is, listen for the fetal heart sounds and test your urine. From time to time, he may wish to have other tests made. The information he gets from these repeated examinations will be the basis for the decisions he makes with you and the guidance he gives you throughout your pregnancy.

Plan for your family

A new baby can be a happy event in a family. This is especially true if the baby is wanted and planned. Now that you are expecting a baby, you and your husband talk over how many other babies you want and when you want them.

When you plan your family, both you and your husband can be happier because you two won't be worrying about having another baby until you are ready.

There are many ways to be sure you will have your babies only when you want them. Your doctor will help you find a way that best suits both you and your husband.

How a baby grows before he is born

WOULD you like to know more about what is happening inside of you as your baby grows? This section will tell you in a general way how this growth takes place.

The organs of reproduction

Your first menstruation was a sign that your childbearing organs were maturing. These are the organs shown in the picture on page 10 of this pamphlet. They are located in the lower part of your abdomen, placed so that each one can do its work best in relation to the others.

In the center is the uterus (womb). This is pear-shaped, hollow, and quite small, normally about 3 inches long. It narrows at the lower end into a neck-like portion called the cervix, the mouth of the womb. This, in turn, leads into the vagina which, together with the cervix, forms a continuous passage from the uterus to the outer world. The walls of the uterus are made of thick, strong muscle. These walls expand as the baby grows and go back into place after he is born. The infant comes out through the cervix and the vagina, both of which enlarge to let him pass.

Curving away from the two upper corners of the uterus are two very small tubes, the Fallopian tubes. These lead out into your abdominal cavity, one to the right and one to the left. At the outer end, each spreads out in an umbrella-like formation close to a small almond-sized organ called an ovary. These two ovaries hold the female sex cells (the eggs, or ova)—about 300,000 in each one. Out of this large supply, only about 400 actually reach maturity during a woman's life time. Of these 400, only a few are finally fertilized and go on to become human beings.

How conception takes place

About every 28 days, midway between two menstrual cycles, changes take place both in the ovaries and the uterus. An ovary begins to get ready to release one of its ova. At the same time, the lining of the uterus starts to grow. Tiny glands and blood vessels appear in the top half of this lining and the whole of it becomes soft and velvety.

About 14 days before the menstrual flow, a single ovum leaves one of the ovaries, stops for about 24 hours at the entrance to a Fallopian tube, then goes on through the tube into the uterus. If conception does not take place, the lining of the uterus then gradually stops growing and comes loose. As it loosens, the blood vessels that come away with it begin to bleed. This causes the menstrual flow of blood, which lasts several days. It carries away the unused top layer of the lining of the uterus, and any other

waste materials that may be present. As soon as this first menstrual period ends, preparation for another one begins. This cycle repeats itself, except during pregnancies, until the menopause, when the childbearing part of a woman's life comes to an end. Most women reach the menopause in their forties or early fifties.

When there is going to be a baby, the story is quite different. Male sex cells (spermatozoa) enter the upper vagina in millions. These cells are much smaller than the ova, and move by lashing their long slender tails. Within 10 to 20 minutes, they swim through the cervix into the uterus itself and up through the Fallopian tubes. If there is an ovum in either of the two tubes, a spermatozoan will usually succeed in entering and combining with it. This is fertilization. Conception cannot take place if the spermatozoan is late in arriving, since the ovum is capable of being fertilized for only about 12 hours after it is expelled from the ovary into one of the two Fallopian tubes.

The placenta

The fertilized egg passes through the tube into the uterus in 3 to 5 days. At the end of about 6 days, it sinks into a spot in the wall of the uterus. The layer of lining which has grown and been discarded so many times before is now receiving the fertilized egg. At this place in the lining, an organ called a placenta begins to grow. This is disc-shaped, slightly raised and covered by a transparent membrane. Blood from the mother circulates in it and so does blood from the baby (fetus).

Blood from the fetus flows in and out through two arteries and a vein. These arteries and the vein are incased in the umbilical cord, which attaches to the surface of the placenta at one end and to the baby's navel at the other. The waste products of the fetus are carried through the arteries of the umbilical cord into the placenta, where they are exchanged for oxygen and nutrients from the mother. The vein in the cord carries these materials back to the baby. The main purpose of the placenta is to make possible this interchange although it is believed to have other important functions as well. It comes out of the mother's body after the baby is born. You have probably heard it referred to as the "afterbirth."

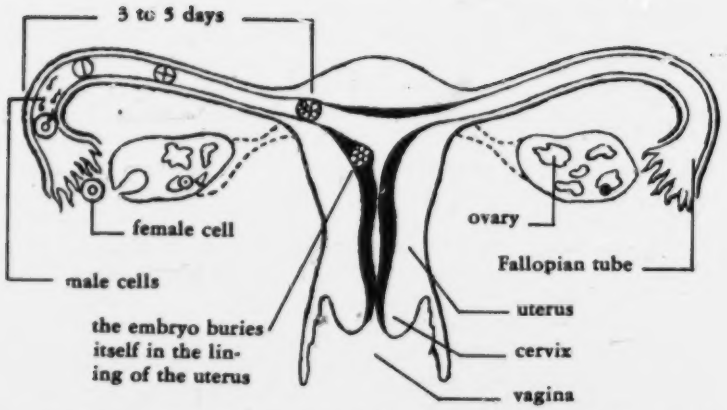
The development of the baby in the uterus

During the first week of uterine life, your future baby is just a group of tiny cells. In the beginning there is but the one cell, formed by the union of two sex cells—a spermatozoan and an ovum. This original, single cell soon divides into two cells, which stay together. Each of these two divide, again into two, and so the process goes on. It is through this on-going cell division that all human beings grow and develop. This enlarging cluster of cells is called at first a zygote, then an embryo, then a fetus.

About two weeks after conception an embryo is still barely large enough to be seen with the naked eye. The place where a head and brain will later develop is growing very fast, however, and there are little indentations where the eyes will be.

At the end of four weeks your baby is still only about a quarter of an inch long. This is a particularly important time because now the internal organs—heart, liver, digestive system, brain and lungs—are beginning to form. The heart begins to beat, although no one will be able to hear it for many weeks. This is when you are probably beginning to think that you may be pregnant.

At five weeks the embryo is the shape of a tiny quarter-moon. His backbone



the process of fertilization and movement of the fertilized embryo through the tube and into the uterus

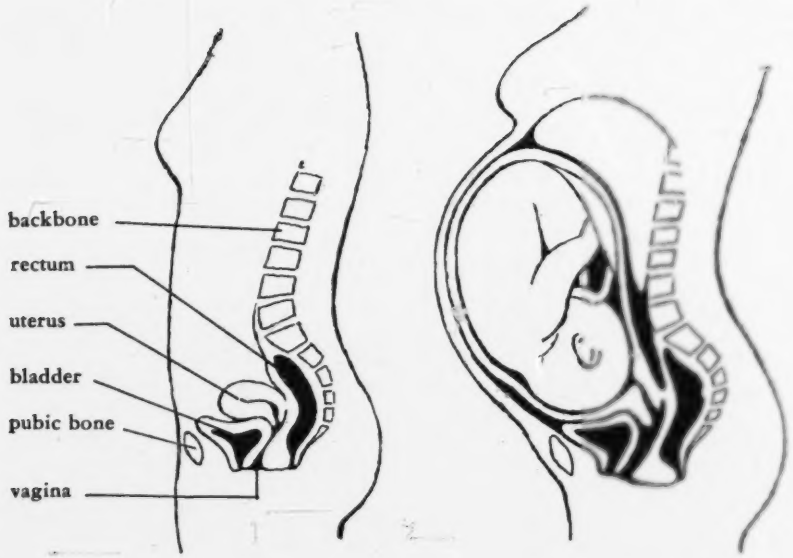
has started to form. His head is growing much faster than the rest of his body, and will keep on doing so until after he is born. Tiny limb-buds appear, the beginnings of his arms and legs. At six weeks, he is almost half an inch long. The four limb-buds have grown into arms and legs.

By the seventh week ears and eye lids are forming and the internal organs are moving into place. The embryo is now floating in a sac of fluid which is sometimes called the "bag of waters." If you are wondering why he doesn't drown, there is a simple answer: He cannot because he does not use his lungs to get oxygen until he comes out into the air at birth. He gets all the oxygen he needs from your blood. The fluid keeps him evenly warm and also acts as a shock absorber to protect him from any jolts or bumps he might get from your ordinary activity.

After the eighth week the embryo is called a fetus. ***In the third month*** of pregnancy, he is about 2½ inches long and weighs about an ounce. Your abdomen is beginning to enlarge. The baby's fingers and toes are usually well formed by the fourth month and tiny nails begin to show. His back is still curved like a bow, but his head is straightening up. A little hair, usually dark, is starting to grow on his scalp and his teeth are forming, deep in his gums. In both sexes, the external sex organs have now appeared. ***At sixteen weeks*** the fetus is 4 to 5 inches long and weighs about 4 ounces. His muscles are active and you may possibly feel their contractions.

Sometime during ***the fifth month*** the doctor may hear the first, faint fetal heart beat through his stethoscope. You will probably notice light fluttering movements as the fetus stretches his arms and legs. These movements begin about five calendar months before the expected time of birth, so it is well to make a note of the date. ***At twenty weeks*** the baby is about 8 inches long and 10½ ounces in weight. Now your pregnancy really begins to show.

From this time on, your abdomen will get bigger quite rapidly. ***By the sixth month*** the baby's movements are real thumps. You may at times be able to see them. Sometimes he lies on one side, sometimes on the other, sometimes with his head down, sometimes with it up. When he is ***about seven months*** "along"



side view of a woman's body, showing the relationship of the bladder, uterus, vagina, rectum, and pelvic bones

he will probably take one position and keep it until after he leaves your body. At times you may not feel him at all. Babies have periods of waking and sleeping before they are born, just as they do afterwards.

During the last two or three months of uterine life, a baby grows "tall" very fast, gets his body fat, and rounds himself out. ***From the sixth month on*** until shortly before birth, he is covered with downy fuzz. A soft creamy substance called vernix begins to form on his body ***at about the seventh month.***

During the eighth and ninth months he becomes more and more like the typical full-term child. The cartileges of his nose and ears develop. His nails, still paper thin, grow beyond the tips of his fingers and toes. The bones of his skull become harder and are becoming more closely knit. The hair on his head grows longer. His eyes, like the eyes of all newborn babies, are slate-blue. You will not be able to tell, when he is born, what color they will be later

This is indeed a sketchy account of a child's growth during the first nine months or so of his existence. If you want to learn more about your baby's development, ask your physician, public health nurse or librarian to suggest some books on the subject. In a prenatal class, you will have opportunities to find out many of the things you want to know. (See p. 82.)

There are four questions of such general interest to expectant parents that it seems appropriate to try to answer them here: How does it happen that some people have twins? Can you tell beforehand whether a baby will be a boy or a girl? Can a baby be "marked" before his birth?

Does it matter how old a woman is when she has her first child?

Multiple births

Doctors speak of twins, triplets and quadruplets as multiple births. It is quite rare for mothers to have three or four or more babies at the same time. Twins are more common, but your chance of having twins is only about 1 in 90. Multiple births are more frequent in some racial stocks than others and tend to run in families.

In earlier times, parents were usually taken by surprise when two or more babies appeared instead of one. Nowadays, your doctor has several ways of knowing in advance when this is going to happen. He may hear two distinct fetal heart beats or he may even feel two separate babies as he examines your abdomen. An X-ray anytime after the fifth month will usually settle the matter.

There are two kinds of twins, "fraternal" and "identical." Fraternal twins are different babies from the beginning. They come from two separate cells, each one of which was separately fertilized. Each baby has its own placenta and its own bag of waters. Two such separate babies may develop either because both ovaries released a cell at the same time or because, for some reason, one ovary discharged two cells at once. These babies are just as different, one from the other, as any two brothers and sisters. Boy and girl twins are always of this type, although fraternal twins may also be of the same sex.

Identical twins form in another way. They begin, as babies usually do, with the fertilization of a single ovum. But when the new single cell begins to divide, the two halves separate. Each of the two new cells thus formed has all the powers of life and growth. The two babies resulting are usually attached to the same placenta but in about 30 percent of cases each has his own. They always have separate umbilical cords and separate bags of waters. These children are always of the same sex and look so much alike that even their parents sometimes have trouble knowing which is which.

The baby's sex

A baby's sex is determined by the male cell that fertilizes the ovum. There are two kinds of male cells in almost equal proportions. One kind carries chromosome X; the other, chromosome Y. When a female cell unites with a male cell bearing the Y chromosome, the result is a boy. When the chromosome in the male cell is X, the result is a girl. Apparently it is a matter of chance which kind of male cell first reaches and fertilizes a particular female cell. There is as yet no reliable method of predicting the sex of an unborn child.

"Marking" before birth

Can a baby be "marked" before birth by his mother's thoughts, feelings or experiences? There are no nerve connections between you and your baby, so what you see, hear or think cannot affect him directly before he is born. Under some circumstances, severe and prolonged emotional disturbances may cause chemical changes in your body which affect the behavior of the uterus. Except in extreme cases, however, the baby is protected from the possible harmful influence of such changes.

There is very little chance that your baby can be affected by the shifts of mood, so characteristic of pregnancy, or the occasional outbursts that clear the air. If you are comfortable with your own feelings, your baby will be too.

Under certain conditions, tobacco smoke, alcohol, excessive fatigue and radiation may bring about changes in your body chemistry. Little is positively

known, as yet, about the effects of such changes on fetal development. A moderate amount of smoking or drinking may not harm either you or your child but this is something you should check with your doctor about. In the unlikely event that radiation exposure from fallout should reach a level that calls for any special precautions, your doctor will be fully informed and can advise you.

There is no known way for a mother to instill special interests or talents into an unborn child. You may want a baby who is gifted in art or music, but no matter how faithfully and intently you may "think" music or painting or sculpture, he will have to grow in his own way. It will be much, much later before you can tell whether he has the talents you wish for him.

Age of the mother

Does the age of the mother affect her chances of a successful pregnancy? It is true that the years between 20 and 30 are usually considered optimum for childbearing. But every year, many thousands of older mothers in this country give birth, without difficulty, to healthy children. The basic reproductive processes are exactly the same for every expectant mother, regardless of the age at which she becomes pregnant.

It is true, however, that women in the older age groups have a poorer overall maternity record than the younger women. This is largely because they have lived longer and had more opportunities to develop medical problems that may complicate a pregnancy.

All maternity patients require the same thorough examinations and the same careful medical supervision, whether they are old or young. If for any reason your doctor thinks you need special attention, he will discuss his findings with you and plan with you for the kind of care you need.

Your food and your health

FOOD does make a difference!

No matter how old you are, or where you live, or what kind of work you do, your good health depends to a very great extent on the food you eat. This is especially true during pregnancy when you must satisfy your growing baby's needs for nourishment in addition to your own.

Your doctor will help you as much as he can with your meal planning but this part of your prenatal care is your special responsibility. You have every reason to feel proud when you make a good job of it. The expectant mother who regularly eats the right food while she is carrying her baby is more likely to have

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a normal pregnancy and less likely to have complications than one who does not. She is also more likely to have a healthy child and a good supply of milk for breast feeding.

No matter how good you think your eating habits are now, it will pay you to check your diet with the information about nutrition that you will find in the next few pages of this pamphlet. Once you have in mind what you need, it will be easy for you to choose the foods that supply you with the materials necessary for growth, for the repair of worn-out tissues, for the manufacture of energy and for your general well-being.

If you have always eaten well, the chances are that you will not have to make many changes in your food because of your pregnancy. You may have been told that you are "eating for two." This is true but it does not mean that you have to eat twice as much as you usually do. Even a bouncing breast-fed baby does not need as much food as his mother. It does mean that you will be feeding two people as long as you are carrying or nursing your baby. Many expectant parents become quite interested in figuring out how best to do this. For you, the mother, it is a question of choosing and eating the right amounts of the right kinds of food.

Food values

What should you eat? Each day your food should supply you with three different kinds of essential building materials (nutrients): ***proteins*** for the growth and repair of your body; ***minerals*** and ***vitamins*** for growth, and to keep your body in good working condition; ***fats*** and ***carbohydrates*** for energy.

Although most foods contain more than one of these nutrients, no single food has in it all of the nutrients you need in the required amounts. This is why it is so important for you to have variety in your meals. This variety, however, is no hit or miss affair. In a good diet, foods are combined in accordance with a few simple rules. Meal plans made according to these rules need not be monotonous. There are so many different kinds of food to choose from that you can nearly always work out menus that meet your needs and your baby's from among the things that you and your family really like to eat. The foods that are good for you, by the way, are good for your family.

To do this kind of meal planning, you need to know (1) what foods are essential, (2) how much of each essential food you should eat, (3) which foods can be used interchangeably, and (4) how quantities of different foods are measured and compared. A good deal of this information you will find in the next few pages of this pamphlet. If you want more, ask your doctor, a nurse, or a nutritionist to suggest one or two books for you to read. There are many excellent free booklets on nutrition available through your local health department or your home demonstration agent.

Groups of essential foods

Foods are classified into groups on the basis of the chief nutrients in them: the milk group, the meat group, the vegetable group, the bread and cereal group, fats and oils, and sugars and sweets. In planning meals for the day, choose foods from each of these groups.

The foods listed in these groups are similar in nutrient content, but portions of equal size vary in the total quantity of each nutrient. For example, a half cup of orange juice contains more than twice as much vitamin C as an equal amount of tomato juice. Most foods contain more than one nutrient. No single food contains all the nutrients in the amount needed. Therefore, choosing an

adequate diet wisely means selecting a variety of foods that together will supply the nutrients needed.

The tables

Some people find it easier to plan meals if they can see at a glance what they need to remember about the different foods. The three tables here may help you in this way. Table 1 includes the principal food groups, the foods in each group, the principal nutrients in these foods, and some other useful information. It also shows, roughly, how much you need to take of each of the different foods within each group in order to get what you need from your food.

Table 2 lists the foods you need to eat and tells you how much of each one you should take each day during the first half and the second half of your pregnancy. The fourth column of this table gives the daily amounts of each of the essential foods recommended for nursing mothers. If you are not sure how "servings" of different foods compare with each other, look back to the last column of table 1. The most important comparisons are made there for you.

In table 3 are sample meal plans for one day for a pregnant woman whose weight is normal and for a pregnant teenage girl who is still growing. These combinations, of course, are just suggestions. Using these sample meals as guides, you can make your own menus, choosing for each meal the foods in each group that you and your family like best. How much you eat of each of the essential foods will depend on your total daily allowance. Your doctor will advise you about this, taking into consideration your weight, your age, any allergies or other health problems you may have, and your previous food habits.

In these three tables you will find most of the information you need for planning meals that will be appetizing and nutritious for you and your family.

Meals and snacks

You can take part of your day's food in the form of snacks between meals and at bedtime. Some doctors recommend five smaller meals a day instead of three larger ones. This is the plan in table 3

This kind of meal schedule may have real advantages for you. When you eat only three meals a day, you are apt to get very hungry in between. If you take smaller amounts of food at more frequent intervals, you are not likely to have this extreme hunger. This way of eating may also help keep you from feeling nauseated, and the hot drink at night may help you sleep.

Whatever eating plan you decide to follow, make sure that the foods you need every day (table 2) are all in it, in the right amounts. Then do your best to stay on your schedule, avoiding extras, especially the food treats that are high in calories. Before you know it, you can gain a lot of weight by nibbling. If you sometimes feel that you just must have a snack between meals, milk, fruits, and raw vegetables are your best choice.

Fluids

Just as important as any of the solid foods you eat are the fluids you drink. A liquid is sometimes described as "anything you can pour from one cup to another." This may not be a scientific definition but it is a good practical one. Your doctor may recommend that you have as much as 2 quarts of liquids every day during your pregnancy. Milk, soups, and fruit juices may be counted in the total amount of fluids suggested, but most expectant mothers need to drink several glasses of water a day in addition. Tea,

(*Continued on page 20*)

Table 1. The Basic Food Groups and What Is In Them

Food groups	Foods in each group	Principal nutrients in foods in each group	Additional information
Milk Group	**Milk** Fresh fluid—whole and skim Evaporated Dry Buttermilk **Cheese** **Ice cream**	**Calcium**—milk the leading source of this mineral **Protein, riboflavin and vitamin A** Many other vitamins and minerals	One 8-ounce cup of milk contains about the same amount of calcium as: 1½ ounces cheddar cheese or ¾ pound creamed cottage cheese or 1 pound cream cheese or 1 pint ice cream Calcium tablets are not a substitute for milk because they contain no protein or riboflavin
Meat Group	**Beef, veal, lamb, pork, liver, heart,** other **variety meats** **Poultry** **Fish**	**Protein, iron, thiamine, riboflavin, niacin** Liver is an excellent source of vitamin A	A 2–3 ounce serving of lean, cooked meat, poultry or fish (without bone) is roughly equal in protein to any one of the following: ½ cup of any of these diced 1 medium-sized patty 1 slice roast meat or poultry 5x2½x½ inch 1 slice round steak 4x2x1 inch 2 frankfurters 1 medium shoulder lamb chop 2 small slices of liver 2 thin slices meat loaf 1 medium chicken leg (fryer) 1 medium-sized fish steak 1 cup dry beans or peas (cooked) 4 tablespoons of peanut butter
	Eggs	**Protein, iron, vitamin A, riboflavin**	

	Dry beans and peas—all kinds including soy beans and soy products, cow peas, lentils	**Protein**—good but of lower quality than the protein in milk, meat, eggs	
	Nuts—all kinds, including peanut butter	**Calcium, iron, thiamine, riboflavin and niacin**—some	
Vegetable-Fruit Group	**Citrus fruit** Oranges Grapefruit Tangerines Other citrus fruits **Tomatoes**	**Vitamin C** (Ascorbic acid)—citrus fruits and tomatoes a main source of this vitamin	4 ounces (½ cup) of orange or grapefruit juice is equivalent to: 1¼ cups tomato juice ½ medium-sized cantaloup ½–¾ cup fresh strawberries 1 cup shredded cabbage ½ cup broccoli ¾ cup dark-green leafy vegetables such as collards or kale cooked briefly in a little water 2 tangerines
	Dark-green leafy and deep yellow vegetables Broccoli Green peppers Greens—all kinds Carrots Pumpkins Sweet potatoes Yellow winter squash	**Vitamin A**—these vegetables all rich in this vitamin **Riboflavin and niacin** in worthwhile amounts **Calcium**—some **Vitamin C** Broccoli, sweet potatoes and some dark-green leafy vegetables are a good source of vitamin C as well as the above nutrients	A serving of a fruit or vegetable is usually ½ cup or an ordinary portion such as: 1 medium apple 1 medium banana 1 medium orange 1 medium potato ½ medium grapefruit ½ medium cantaloup
	Potatoes, white **Other vegetables and fruits**—all varieties not listed, such as: Asparagus Green lima beans Snap beans Beets Brussels sprouts Apples Bananas Berries Dates and figs Grapes	**Vitamin C, iron, thiamine, riboflavin, niacin**—some **Vitamins and minerals**—these are found in different amounts in this group	Fruits and vegetables in this group cannot be substituted for vegetables and fruits in the vitamin A and vitamin C-rich groups

Table 1. The Basic Food Groups and What Is In Them—Continued

Food groups	Foods in each group	Principal nutrients in foods in each group	Additional information
Bread-Cereal Group (whole grain, enriched or restored)	**Breads** and other **Baked Goods** made from any grain—wheat, corn, oats, buckwheat, rye **Cereals**—to be cooked or ready to eat **Rice, hominy, noodles, macaroni**	**Iron, thiamine, riboflavin, niacin**—in significant amounts if bread or cereal is **whole grain, restored,** or **enriched** with **vitamins** and **minerals** Foods in this group have some **proteins** and **calories** and are high in **carbohydrates**	One serving of cereal is equal to: ½–¾ cup cooked whole grain or enriched cereal, cornmeal, grits, macaroni, noodles, rice or spaghetti or 1 ounce ready-to-eat cereal or 1 medium slice of enriched bread
Fats, Oils	**Butter** and **margarine** **Salad oils, mayonnaise, salad dressings** **Lard, shortening, meat drippings**	**Rich** in **vitamin A** Vegetable oils provide **essential fatty acids** **Calories**—all fats furnish many of these for body energy	Fats may be included as an ingredient in food preparation
Sugars, Sweets	**Sugar**—any kind: granulated, beet or cane, brown, confectioners, and maple **Molasses** **Sirup** or **honey**—any kind **Jams, jellies, preserves** **Candy**	**Calories**	Sugars may be included as an ingredient in food preparation

Compiled for this publication. Chief sources of information: *Nutrition Up To Date To You*, Home and Garden Bulletin No. 5, revised September 1960, U.S. Department of Agriculture, and *Nutrition During Pregnancy and Lactation*, revised 1960, California State Department of Public Health, Berkeley, California.

Table 2. The Foods You Need Each Day

Food item	Before and during the first half of pregnancy	During the latter half of pregnancy	While nursing your baby
Milk, pasteurized—includes whole, nonfat, evaporated, reliquefied dry, or buttermilk	1 pint	1 quart	4 cups or more
Lean cooked meat, fish, poultry or meat alternate. Use liver or heart frequently	1 serving (2–3 ounces)	1–2 servings (5 ounces)	3 or more servings
Egg	1	1	1
Dark green or deep yellow vegetable	1 serving	1 serving	5 or more servings
Fruits and vegetables rich in vitamin C Good sources: citrus fruit or juice, cantaloup, raw strawberries, broccoli, peppers Fair sources: other melons, asparagus, brussels sprouts, raw cabbage, greens, tomatoes or juice, fresh or canned chili, potatoes cooked in jackets	 1 serving or 2 servings	 1 serving and 1 serving	 1 serving and 2 servings
Other vegetable or fruit	1 serving	2 servings	2 servings
Whole grain, restored, or enriched cereal Whole grain, restored, or enriched bread	1 serving 2–3 slices	1 serving 2–3 slices	4 or more servings 3 slices
Butter or fortified margarine	Amount as caloric level permits	Amount as caloric level permits	Amount as caloric level permits
Vitamin D		Use according to physician's instructions	Use according to physician's instructions

Adapted from *Nutrition During Pregnancy and Lactation*, revised 1960, (p. 18). California State Department of Public Health, Berkeley, California.

Table 3. Sample Menus for the Second Half of Pregnancy

For pregnant woman of normal weight	For pregnant adolescent girl of normal weight
Breakfast Orange slices Shredded wheat Scrambled egg Toast—1 slice Butter or margarine Milk—½ pint Coffee	Breakfast Orange juice—8 oz. Shredded wheat Scrambled egg Toast—2 slices Butter or margarine Marmalade Milk—½ pint
Lunch Meat sandwich Carrot and green pepper sticks Oatmeal cookies Milk—½ pint	Lunch Meat sandwich on whole wheat bread Carrot and green pepper sticks Cheese cubes Oatmeal cookies Fresh fruit Milk—½ pint
Midafternoon Milk—½ pint	Midafternoon Chicken sandwich Milk—½ pint
Dinner Broiled beef liver Steamed broccoli Baked potato Tomato salad with French dressing Baked apple	Dinner Broiled beef liver Steamed broccoli Baked potato Vegetable salad with French dressing Baked apple with raisins Milk—½ pint
Bedtime Hot milk or cocoa—½ pint	Bedtime Milk or cocoa—½ pint

Selected from "Recommended Diet Plan," *Nutrition During Pregnancy and Lactation*, revised 1960, (p. 28). California State Department of Public Health, Berkeley, California.

coffee, and other beverages may be used, but ask your doctor about these.

Iodine

If you live in a part of the country where there is not enough iodine in the soil, you may need to add a source of iodine to your diet—and to that of your family for reasons of general health. The simplest way to do this is to use iodized instead of plain salt for seasoning. Ask your doctor about this. Iodine should not be used as treatment for a thyroid condition unless it is prescribed by a physician.

Salt

Pregnancy alone does not necessarily cause an expectant mother to limit the amount of salt she uses. If your doctor thinks you should use less salt in your diet, he will tell you so. The need for restricting salt in the diet varies with the individual.

If your doctor has told you to cut down on salt, keep it where you can't reach it on the table and leave it out of the food when you are cooking. The rest of the family can add theirs later. After a few days you will probably miss yours less. You will also have to be

the scales tell the story

careful not to eat foods that contain extra salt. Among these are bacon, ham, chipped beef, corned beef, salted and smoked fish, salted nuts, pretzels, salted crackers, popcorn, and potato chips.

Your weight

Must you gain weight because you are pregnant? You will almost certainly be heavier toward the end of your pregnancy than when it began, but you should regain your normal figure after the baby is born. The average full-term baby weighs between 7 and 8 pounds. The placenta and membranes weigh about 1¼ pounds, the enlarged uterus about 2 pounds. There will also be some increase in the size of your liver and the volume of your blood. Your breasts will be a little heavier and your body tissues will absorb and hold more water. These normal increases usually add up to more than 12 pounds.

Many physicians recommend a total weight gain during pregnancy of about 20 pounds. This is a general recommendation however. Your doctor may want you to gain more or less, depending on what you weighed when you became pregnant and on your previous history of weight gains and losses. A sudden gain of several pounds over a short period of time should be reported to your doctor.

Gains and losses in your weight are

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due to gains and losses in the amounts of fat and fluid stored in the tissues of your body. Your doctor will prescribe diet and other measures if you have trouble with water retention. In general, the amount of fat stored depends on two things, the amount and kind of food you eat, and the rate at which you use this up. When your food gives you more energy than you need, the excess is stored as fat. Large stores of fat are unhealthful and unsightly. When your food does not give you enough energy, you keep going by using up the fat that has been stored and then drawing for energy upon other tissues. This is not good either for you or for your baby. You can do a great deal to keep your weight within bounds by eating more or less of foods that are rich in calories.

A calorie is the unit of measurement commonly used in expressing the energy values of foods. Some foods have many calories, some only a few. If you gain weight easily, eat very little candy, pastry or cake, and be careful about gravies, rich sauces, salad dressings made with oil, soft drinks containing sugar, beer and ale, alcoholic beverages and the snacks that are so often served with them. All these foods have many calories. There are hidden calories in all fried foods because of the fat or oil they absorb while they are cooking.

To keep down your weight, you will choose foods to eat that have fewer calories. To add pounds, you will favor the foods that are high in calories. Table 1 on pages 16–18 will help you to select foods for your menus that have the essential nutrients as well as the calories you require.

Expectant mothers sometimes think that if they eat very little, they will look better, the baby will be smaller and the birth easier. Recent studies seem to show that the size of a baby is not closely related to his mother's diet. As for looks, the better fed you are, the better you will feel and the more attractive you will be.

Rest and sleep

Pregnant women live and work under many different kinds of circumstances. This may be your first child or your sixth. You may do all of your housework or none of it. You may have time on your hands or not half enough time to do what you have to do in a day. Whoever you are and wherever you are, you will probably find that you need 8 hours sleep out of the 24. People differ in the amount of sleep they seem to require, however.

Rest periods during the day help to conserve energy. These daytime rest periods can be short and still beneficial if you really relax. Take off your dress and lie down for 10 or 15 minutes in the afternoon. If you have little children, perhaps you can do this while they are taking their naps. Practice "letting go" until you get that "rag doll" feeling. It is also refreshing to sit down several times during the day with your feet up. You will be surprised how much better you will feel in the evening if you take these bits of time out. Many of the things you do around the house, you can do just as well sitting as standing.

If you are working outside of your home, it may not be easy to find a place and the time to rest. Some employers provide a rest room for their employees and extra rest periods for pregnant women. Should these facilities be lacking where you work, you might consider discussing the problem with some one in authority. In any case, try to sit with your feet up for a few minutes after lunch or when you get home from work.

Exercise

A moderate amount of enjoyable exercise will be good for you during your

pregnancy, unless you have been ill or have a complication of some sort that keeps you from being normally active. The awkwardness of your body late in pregnancy will tend to slow you down somewhat, but you can probably keep on with most of the things you have been doing until the baby is due. The kind of exercise that is right for you will help your digestion and your circulation. It will help to develop your muscles and give them tone. Indeed, it will help you to feel better all over.

Plan to spend some time out of doors every day. Gardening is an excellent way of getting fresh air as you work. Most of us are so used to cars and buses that we forget how pleasant it can be to walk to the store or to the house of a friend. Your doctor will want you to avoid heavy lifting, the pushing and pulling around of heavy things, and the more strenuous sports, like diving. Swimming is usually permissible but only if you have someone with you who can help in case you have a cramp. It is important not to let yourself get too tired. When you have something heavy to carry, ride.

Work under pressure is more tiring than work done more slowly with frequent short rests. If your indoor work involves much exercise, it may be better for you to rest when you are out of doors, especially in nice weather. It is good to relax in the sunshine, if you don't overdo it.

These suggestions are fairly general but they add up to an attitude that is quite specific: A normal pregnancy is not a sickness. The positive forces of life are very strong in you when you are producing a baby and, far from being an invalid, you may feel better now than you ever have before.

exercise can be fun

Your clothing and personal hygiene

Clothing

When you are four or five months along, your pregnancy will begin to show. Your waist bands will seem tight and nothing you put on will feel just right. This is the time for you to start wearing clothing designed for expectant mothers. Most department stores and some of the women's specialty shops have pretty maternity things for sale. There are many attractive patterns to choose from if you would rather make your own.

You will only need this type of clothing for a comparatively short time, so you will not want to spend a great deal for it. In many cities, there are thrift or commission shops where dresses and other articles of clothing in excellent condition are often sold for much less than their original cost. If you have never been in one of these resale stores, watch for a chance to visit a good one. You may find an attractive maternity outfit there at a very reasonable price.

In making or buying maternity clothes, avoid anything tight or binding around the waist. The skirt of a modern two-piece maternity suit has an extendable belt and an elasticized section in the front panel under the smock. Dresses and slips that hang from the shoulders are good because they do not put pressure on the abdomen.

Whatever you do, get yourself becoming things. There is no reason today why any woman should wear anything drab, ill-fitting, or makeshift just because she is pregnant. You can look particularly well at this time if you take a little trouble to find colors and styles that suit you. Pretty clothes are excellent morale builders.

Panties should be loose enough to adjust easily as your waistline expands. Some have special sections of soft elastic in front.

Brassieres and girdles

It is important for you to wear a good supporting brassiere from the beginning of your pregnancy. This will help your breasts retain their shape. It will also improve your posture and appearance and add to your comfort. The best type has a full cup, wide shoulder straps, is designed to support the breasts from underneath, upward, toward the opposite shoulder, and never "binds." After the fifth month, your breasts will probably not become any larger, so the brassiere that is right for you then may continue to fit for the rest of your pregnancy. Some women wear nursing brassieres even during pregnancy. If you are going to nurse your baby, this is economical because these brassieres have tucks that can be let out after the baby comes.

Your doctor can help you decide

whether or not to wear a girdle. If you never have, you may not need one now. If you are used to this kind of support, you should probably continue to have it, but the girdle should never be too tight.

An ordinary elastic girdle without bones will do for the first two or three months. After that, if you wear a girdle at all, you may need a special maternity corset with adjustable sides and back, fitted to your measure. You put it on differently than you do an ordinary corset. Lie down on your back, pull it up into position over your legs, and start fastening at the bottom. If you prefer, you can put it on in the usual way, without hooking it, and then lie on your back to fasten it. You may feel like a contortionist the first time you try this, but don't give up. Hooking your girdle up from the bottom gives your uterus more support. Later in your pregnancy, it will be easier to get into this garment lying down than to struggle into it standing up. Sometimes it helps to put a pillow under your hips.

Shoes

Nothing you wear at this time is more important than your shoes. The increasing weight in your abdomen changes your posture, putting strains on your body in new places. Properly fitted shoes with flat, low, or medium heels will help to balance you. You will certainly want to avoid shoes that do not fit and shoes with extreme heels because these will add to the danger of your falling. Flat, shapeless moccasins are not good either, because they do not support your arches.

If you have always worn high heels, you may miss the dressed-up feeling they give you. Some doctors advise against shifting back and forth from high to low; others approve high heels for special occasions. This is something for you to take up with your physician. He will probably suggest that you try shoes with heels of different heights until you find the type that is most comfortable for you. You will discover that sensible shoes for expectant mothers come in many pretty styles.

Having found shoes that feel just right on your feet, why not stick to them, at least for everyday wear? If you do, you will carry yourself better, you will not be so tired at the end of the day, and you may avoid a good many backaches.

Bathing

A bath every day will refresh and relax you. It is one of the best ways to care for your skin at all times but particularly during pregnancy when perspiration may be a problem. If you perspire excessively, don't be unduly concerned. This is one of nature's ways of taking care of the waste products from your body and the baby's. There are many excellent deodorants on the market and you will probably want to use one.

Until sometime in the eighth month, it is usually all right for you to give yourself tub, shower, or sponge baths. From then on, it is better not to use the tub because you may find yourself quite clumsy and you might fall getting in or out. In the shower, stand on a rubber mat or a bath towel so you will not slip. You may feel more comfortable about bathing toward the end of your pregnancy if you wait to do this until your husband or some other adult is at home to give you any help you may need.

Care of your teeth

It is customary for an expectant mother to see her dentist soon after she becomes pregnant. Your doctor will probably want you to do this. If you have cavities, they should be filled to prevent further decay. A tooth that needs to come out can be pulled unless there is some special reason for not doing so. On the other

hand, it is better not to have a lot of complicated dental work done at this time. You need to be able to eat regularly, and repairs that interfere with this should wait, if possible.

Sometimes during pregnancy, the gums become redder than usual and bleed easily. Be sure to consult your dentist or your doctor if this happens in your case and the condition persists. The difficulty may be nutritional. Mouth infections should be cared for immediately.

Care of your breasts

Whether or not you expect to nurse your baby, you will want to keep your breasts in the best of condition. During all of your pregnancy, they should be clean and comfortable. Wash them as you do the rest of your body when you take a bath or shower. If your skin is sensitive to soap, your doctor may suggest a substitute.

About the fourth month, a colorless fluid called colostrum begins to ooze from the nipples. This means that your breasts are preparing to produce milk. If this secretion forms a crust, use a little cold cream, lanolin or cocoa butter to soften it. Small squares of gauze worn over your nipples will keep the colostrum from coming through onto your clothing.

Your doctor may suggest that you apply a cream of some kind to your nipples to toughen them for nursing. If they become inverted, he may advise you to massage them gently. He will show you how to do this. He will want you to let him know immediately if a breast or nipple becomes sore, hard, or inflamed.

Going places and doing things

Traveling

A pregnant woman can usually take trips by plane, train, bus, or automobile up to the end of the seventh month. Travel by car may present some problems, but these are not necessarily serious. If you tend to be carsick, especially during the first two or three months, take only short trips. If you are not easily upset, riding 100 or 150 miles at a time will probably not cause you any discomfort. It is a good idea to stop for a few minutes, every 50 miles or so, especially if you are driving. Many women continue to drive during pregnancy, although some doctors advise against driving alone in the last month.

Some people think that traveling during the early stages of a pregnancy may cause a miscarriage. There is no evidence to support this belief. Late in pregnancy, however, it is wise to limit travel, chiefly because, on a long trip,

labor might start at an inconvenient time. If you must undertake a long journey after the seventh month, go the quickest, easiest way. It is probably a good idea to talk with your doctor before you make plans for a major trip.

Women whose husbands are in the armed forces or have civilian assignments away from home are subject to specific regulations regarding travel during pregnancy. These rules are not uniform and may be changed from time to time. Be sure to find out exactly what these regulations are if you are a service wife expecting a baby and have any reason to think you may need to take a long trip before your delivery.

Moving

American families move so often, so far, and for so many reasons that you may be one of the wives faced with the task of dismantling and resettling a home during a pregnancy. If this is your situation, go at the job as easily as you can. Let someone else do as much of the lifting, stooping, sorting, and packing as possible. If you have children, let them do as much for you as they can. To be able to help in a family emergency gives most youngsters a warm feeling of pride.

Get your moving over before the seventh month, if possible. Moving and storage companies have had so much experience in packing and shipping household goods that they are usually expert in this work. It will pay you to choose a reliable one and let the representative take charge, under your supervision. If yours turns out to be a last minute move, your family and friends may be able to see to it for you while you are in the hospital.

The actual changeover from the old home to the new should be carefully planned. Do your best to time your departure so that you do not find yourself weary and supperless in an empty house in the middle of the night. Perhaps you can arrange beforehand to stay in a hotel or motel while someone else in your family waits for the furniture. With small children, this is almost a necessity.

Working outside of the home

If you are pregnant and employed, you are probably wondering how long you should stay on the job. That depends on how you feel, what kind of work you do, and how busy you are at home.

Jobs that keep the feet constantly in motion or require a great deal of standing, bending, or lifting are likely to be tiring. If your work is strenuous and cannot be lightened in any way, give it up after the fourth or fifth month. If it is not too heavy, you can probably go on working much longer than that, possibly into the eighth month, provided you get enough rest, eat the right kinds of food, and are reasonably satisfied with the way things are going at home. Your doctor will tell you when he thinks you should stop working. If you work in one of the lead industries, be sure to ask him if there are any special precautions you ought to take.

It is important for you to know whether or not you are entitled to maternity benefits in the p. ce where you work and, if so, what these are. Some States have laws concerning working conditions for pregnant women, and many businesses and industries have cooperated voluntarily in the development of special codes to protect expectant mothers in their employ.[1]

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[1] Information about provisions of this kind is available in a pamphlet called **Maternity Benefit Provisions for Employed Women,** published by the Women's Bureau, U.S. Department of Labor, on sale by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C., for 25 cents. This Bureau has also published another pamphlet which may be helpful to you: **Part-Time Employment for Women** (Superintendent of Documents, 30 cents).

Understanding your own feelings

DIFFERENT women feel differently about being pregnant. The same woman may feel differently about her pregnancy at different times.

For many expectant mothers and fathers, the coming of a child is a thoroughly happy and satisfying experience. Something they have both wanted very much is about to happen. As they share in the responsibility of getting ready for the baby, they appreciate and enjoy each other more, and find new values in their marriage.

Many expectant parents feel this way, a good deal of the time. There are very few pregnant women, however, who do not feel depressed occasionally. If you are a person who is always serene, you may want to skip the next few pages. They will be of more interest to the mothers who are sometimes vaguely unhappy and would like to know why. People usually get along better with their feelings when they understand them.

Changes of mood

If you have already had some experience with the quick changes of mood so common in pregnancy, you know how upsetting they can be. Everything is going along smoothly. You are in high spirits, looking forward to a pleasant evening with your husband. Suddenly you are miserable. You want to cry. In a few minutes you have become the kind of irritable, irritating person no one but a husband would willingly spend an evening with. What do these sudden changes in mood mean?

The simplest explanation for a good deal of the emotional instability that seems to go with pregnancy is a natural one. Your physical self and your emotional self are so closely related to each other that nothing can happen to one without affecting the other. Each stage of your pregnancy will make emotional as well as physical demands on you. You may have realized this for the first time when you learned that you were pregnant. You may have been delighted beyond words. You may also have discovered that it is possible to want a baby very much and suddenly not want it—***now***.

Feelings about pregnancy

Studies of pregnancy show that the feelings women have about being pregnant run the whole gamut of human emotions. Some are overjoyed, the majority have mixed feelings, and some are definitely not pleased. There is no reason for you to be distressed if there are times when you don't feel as you think you should about your family, the baby, and yourself. Tomorrow you will probably be back on Cloud 9 hoping to take your next mood swing in stride.

As the weeks pass, you will find yourself thinking more and more about the pregnancy itself. You will want to be

sure that everything is all right, you will be looking for more reassurance, especially from your doctor, than you may need later on. If this is your first baby, you will naturally begin to wonder how much discomfort there may be later and how much you will mind it. A little "spoiling" from your husband may help very much to give you comfort and security.

As the baby grows bigger and it becomes harder for you to get about, your feelings of anticipation may be mixed with feelings of doubt and perhaps a little healthy resentment. After all, who is having this child? Does my husband really understand what my problems are? How much do I want to give up for a family? Do I have what it takes to be a wife, a mother, a homemaker, and a goodwill ambassador between grandparents and children in his family and mine?

Finally, when it is almost time for your baby to arrive, you may find yourself wondering more about the immediate future: Will my baby be all right? Will I know when to start for the hospital? How long will I be in labor? How much of the time will my husband be with me? Will I "behave" well while the baby is being born?

Helpful activities

In general, the women whose pregnancies are the smoothest, from the emotional standpoint, are the women who learn as much as they can about the facts of childbearing and childbirth, ask questions when something comes up that they don't understand, share their feelings with their husbands, stick to a good health routine, have fun, and follow the advice they get from their doctors.

One of the best ways to get a good general background of information about pregnancy, childbirth, and the care of the newborn is to join one of the study groups for expectant parents, mentioned before in this pamphlet.

For some people, there is magic in the right kind of "busy-ness," a daily round of interesting, varied, and useful activities. Nowadays, most pregnant women are normally active until six or eight weeks before their babies are due. Some, of course, have more to do than is good for them; some have too few responsibilities to keep them really occupied. Whatever your situation, you will be fortunate if each day brings you opportunities for work and play that give you pleasure and a sense of accomplishment.

When your doctor feels that you should be less active physically, spend more time on some of the quieter things you enjoy doing. For mothers who knit, the new patterns and yarns for baby things can be a source of great delight.

If you don't know much about children, you'll be surprised how much you can learn by babysitting for friends or perhaps helping a little in a day nursery.

You may sometimes prefer to be alone, to read or just to do nothing. This is fine; give in when you feel lazy. Nature has a way of slowing you down when you are carrying a child, as if to remind you that you need to be quiet in order to gain strength from your own inner resources. At the same time, every pregnant woman needs some companionship.

Sexual desires

It is very important for you and your husband to be able to talk freely with each other about your thoughts and feelings. Pregnancy lessens the sexual desire of many women, a natural change which sometimes creates misunderstandings. It is much easier to accept and adjust to each other's problems if expectant parents can discuss them and work out ways of managing them together. In this and other personal matters, many couples are greatly helped by the spiritual comfort

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and guidance they receive from their minister, priest or rabbi.

Relieving anxieties

So much for the emotional surprises of pregnancy, the changes in feeling that are normal but often puzzling, because they are so unpredictable. The fears that bother some women are another matter. These fears are, in general, of two kinds: fears that we have when we do not know what to expect or are misinformed about what may happen to us, and fears that we cannot explain, even to ourselves.

There is no good reason for putting up with a fear that can be cured with information. No matter where you live, you can find a way of getting a dependable answer to almost any question you may have about your pregnancy. Your doctor will be glad to tell you and your husband what you want to know. It is a good idea to note down your questions as these come to your mind. If you take this list with you each time you go to see your physician you won't be saying to yourself afterwards, "Now why did I forget to ask him that?"

There are books to read; courses and lectures to attend. (See p. 82.) You can usually find out about these from your doctor, his nurse, or your local library. Good, inexpensive materials on prenatal care are made available by many State departments of health and many private organizations. A postcard to your local or State health department will bring you information about these publications and free copies of some of them.

How to use advice

One of your problems will be to know when the information you receive from other than these official sources is reliable. Many superstitions about conception, pregnancy and childbirth still exist. Some of these do no particular harm but some endanger the health of both mothers and babies. Both kinds may have been handed down in your family and the families of your friends and neighbors for generations.

For your own sake and your baby's, check with your doctor whenever you are in doubt about any advice you receive from relatives or friends. It is also well to check with him when you are puzzled by the claims of rival companies advertising special diets, toilet goods, articles of clothing, medicines and personal accessories for expectant mothers. Some of these claims are fully justified, but some are not. The further you look into these things, the more facts you have to use in making your own decisions about them.

Deeper fears

The deeper fears some women have during pregnancy are more difficult to cope with than the fears due mainly to lack of information. It is harder to know where they come from, partly because they have usually been growing for a long time, and partly because they can disguise themselves in so many ways. They are often the result of frightening experiences in childhood which we can not bear to remember. We can bury the memory of these experiences so deeply in our minds that it is hard to recall them. But the fears created by them do not stay down. Indeed, they spread by attaching themselves to new situations with which they have no apparent connection. It is easy for them to latch on to some of the normal anxieties of a pregnancy.

Fears that seem to come from nowhere do not usually clear up of their own accord. If you have some you can't account for, by all means let your doctor know. If he cannot help you himself, he will probably refer you for assistance to a mental health clinic, a social agency or a psychiatrist in private practice.

The fear of discomfort during labor and at the time of delivery is different from the two other kinds of fears just described. It is very logical, very normal, and much can be done to overcome it. You cannot possibly know in advance just how much you are going to mind the birth contractions, because people feel these so differently. You do know that about four million other women in the United States will also have babies this year, and that most of them will find their labor bearable. Your doctor will give you the relieving medicines that he thinks will be best for you and the baby. (See p. 63.) Do not worry about how you will act. Doctors and nurses have seen mothers behave in every possible way during labor and delivery. They will trust you to do your best.

Fine as it is to be a naturally serene and happy person, it is even better to gain serenity by learning how to manage feelings that might otherwise be disturbing. At first, your feelings about your pregnancy are likely to be an unsteady mixture of hopes and fears. The chances are that this mixture will settle down into a kind of quiet confidence if you can remember that the vast majority of pregnancies run a normal course and produce healthy, normal babies in whom parents take great delight.

You and your family

IT may seem to you that your baby belongs entirely to his parents. In a way he does, but actually he will be born into three families: his own, yours, and his father's. He is important to all of the people related to him because, for each of them, he represents the continuation of the family. On the other hand, the loyalty his three families as a whole can give him will be a big part of his security throughout his life. You can see what an advantage it will be to him if the family atmosphere he comes into is friendly, cooperative, and reasonably free from tension.

Once, young couples starting new families were guided, mainly, by the teachings of their parents and their own beliefs. Today, they have knowledge from many other sources, including a rapidly growing number of scientific studies of family life.

These studies have already told us a great deal about how families grow and develop. They are helping to answer such practical questions as how parents learn to work together, how families decide what they want to work for, how families solve their problems, how values are learned in family life, why young families need relatives and friends.

Parental teamwork

There is one thing, according to these studies, that successful American families seem to have in common—responsible, ***joint,*** parental leadership. There are, of course, many one-parent families, but more than ever today a family needs two parents to see it properly through all the stages of its life cycle. Furthermore, it is not enough for these two parents to be a "married couple." ***They need to be a team.***

Your teamwork started when you and your husband planned together for your wedding, your honeymoon, and your first home. You probably had to find a place to live that suited you both. You had to fix it up and get furniture for it. As you shared ideas and made decisions, didn't you feel that, together, you were getting somewhere you both wanted to go; that you were learning things you hadn't known before about each other's values and beliefs; that you were becoming more clear about your own? You made some mistakes, but you made them together, and by the time you knew you were going to have a baby, you really felt that you were partners.

The quality of your teamwork will be tested, again and again, as the two of you deal with such family issues as family goals, division of family responsibilities, sources of family support, family use of money, religion, children, sex, and the place of the family in community life.

Management of differences

What do you do when you agree, when you disagree, about things that really matter? Some husbands and wives play it "by ear" until they harmonize. Some give up without trying. Some follow, as best they can, the rules for problem solving they learned in school: define the problem; think of several possible solutions; try one; see if it works; if it doesn't, try something else.

You and your husband probably do not always settle your differences in the same way. Sometimes one of you makes the decision and the other agrees to it. Sometimes you compromise, each of you giving up something. Sometimes you can shift things around so that you both get what you want. Sometimes you are able to invent a solution that not only meets your immediate needs but creates opportunities for you both to have new and valuable experiences. The important thing, of course, is to form the habit of settling differences instead of prolonging them by arguing.

Meeting family needs—the long view

With a baby coming, you will be thinking more seriously than ever about what you want for your family and how the plans you make can best be carried out. Since babies are usually fairly expensive, your main concern now may be what to do about major investments. Every family hopes to have, someday, a nice home in a nice neighborhood; a car; such labor-saving devices as a washing machine, a dryer, a vacuum cleaner; perhaps such luxuries as a color television set and air-conditioning. Even more, most people want a good education for their children, and the security of a good lifetime insurance plan. Someday you will likely have all of these things, or their future equivalents. It is your timetable for buying them that is important now.

You and your husband probably started housekeeping with more than either of your parents had. You will get more things more quickly than they were able to do. There is nothing wrong with this, if you have a buying plan that is adjusted to your income and makes provision for large, routine, future expendi-

tures as well as for emergencies. Every family has to be ready to take care of unexpected illness, and to tide over the times when the chief income-producers may be out of work.

It is when we think of future expenses for other babies, for their education, and for their marriages that we realize most fully what a long, long process family development is. It begins with courtship and marriage, but this is ***only*** a beginning. You probably know couples in their seventies and eighties who are still finding new values, new delights in their family living and in their companionship with each other. If you can take this long view of marriage and family development, it will be much easier for you to decide what must be done—or bought—today and what can wait until later. It takes time to meet the changing needs of a growing family—time, careful planning, and patience. Families who try to go too far and too fast in too short a time often find they have lost their way. Many banks, savings associations, and insurance companies have advisers who are glad to help with family financial planning.

Sharing family responsibilities

Closely related to this question of what families work for and how they reach their goals is another one, one about which people often have very decided opinions. This has to do with the way in which husbands and wives share parental leadership. Did you discover, after your marriage, that you and your husband had different ideas about the duties, rights and responsibilities of men and women in homemaking and family living?

There is no one answer to this question. In some families, husbands and wives prefer to be as independent of each other as possible. Each has his own way of life inside and outside of the home. In other families, husbands and wives like to do almost everything jointly. They share the marketing, cooking, cleaning, dishwashing, the care of the children. They may or may not both work outside of the home, but they usually have a joint bank account. They spend their free time together and have the same friends. Still other couples have a more flexible plan. The husband has his responsibilities and the wife her's but each expects to help the other out in an emergency.

If you and your husband are both pleased with the way you share your family responsibilities, the arrangement you have is probably the one that is best for you. Whatever it is, there may have to be some changes in it during your pregnancy. When the baby comes, there will be three people to consider instead of two. Whether or not the gears shift smoothly depends on how well each of you understands what your present relationship means to the other and on how you both feel about your approaching parenthood.

Your own emotional ups and downs (see p. 28) may be a complicating factor. These may completely mystify your husband, especially if this is his first experience with you as a pregnant wife. He has, of course, just as much at stake in this as you do. He must go on with his own work and anything extra he does to make things easier for you must seem reasonable and necessary to him as well as to you. After all, nature is guiding you rather firmly but his responses to your needs and feelings must often be based on sheer guesswork. Even so, most husbands and wives do finally learn how to comfort and encourage each other when comfort and encouragement are needed.

How fathers can help

This kind of companionship does not come overnight. There are certain things two people can do to cultivate it, however, that seem fairly simple. This is why it is so important for you and your husband to see the doctor together from time to time, especially at the beginning of your pregnancy. Then you both hear what he has to say about your condition and about any problems that may be connected with it.

The doctor knows that you may be unhappy at times about your appearance, your diet, or the restrictions that will gradually be placed on your normal activities. He can explain your feelings so that your husband will understand them better. At the same time, he can help you see the need for being as reasonable and considerate as possible.

Traditionally the mother prepares the layette but nearly everything else that needs to be done in advance for the baby, you and your husband can do together. Fathers who are handy with tools often enjoy making things that will be needed later—the crib, perhaps, or a cabinet, playpen or sturdy table. Any public librarian will know where to find designs and instructions for making or repairing baby furniture. When expectant parents get ready for a new baby by sharing both the fun and the work, they usually find themselves looking forward with growing anticipation to the new responsibilities that come with parenthood.

How families grow

You may have known families where husband and wife were so close that they did not really want the baby they were expecting. To be perfectly honest, haven't you sometimes wondered what this child of yours might do to your marriage? Why shouldn't you? A major change is taking place in the inner life of your family. It would be strange if you had no misgivings about it. Yet most people find that fatherhood and motherhood give new depth and meaning to their husband-wife relationship.

The diagrams on page 35 may help you to see how this can happen. Until the first baby comes, a family may be represented by two people facing each other. When the youngster arrives, where do we put him? Between his parents? No. If we do that, they will have to go either through him or around him to reach each other.

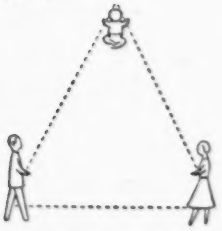
If we think of the family as a three-sided figure, however, we can give mother, father, and baby each a place of his own at one of the corners. No one comes between either of the other two in this arrangement. Each is seen as a personality in his own right, free to work out his own relationships with each of the other two. This will be true if the family later adds one, two, three, four or any other number of members. This is how family "circles" are formed.

If you look, now, at page 35, you will see that a circle has been drawn around our original triangle. At intervals on this circle are the people in your baby's other families: his mother and father, brothers and sisters, his grandfathers, grandmothers, uncles and aunts. Here is your baby's world. Long before he knows anyone in it, he will get the "feel" of it from you and his father. What kinds of feelings are running along those lines connecting the people in the circle with the people in the triangle or the square? No one person can ever be wholly responsible for the feelings of anyone else. But, as everyone knows, the way we act toward people has a lot to do with the way they act toward us.

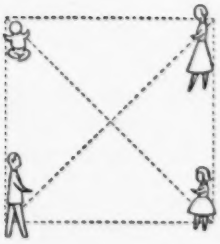
Grandparents

In this country, we seem to have the impression that a family consists of two parents and their child or children. As

first there were two



then there were three



soon there may be four

and still the family grows

a matter of fact, a normal family has three generations and each of these generations needs the other two. Children and grandparents, particularly, need each other so much that the lives of both are impoverished if they cannot know and love each other. Sometimes they are separated because families move apart, sometimes through misunderstandings, sometimes because parents resent interference or fear loss of authority.

Young families do need privacy and freedom to do their own growing. At the same time, grandparents need to feel useful, to be able to give and receive affection. This does not mean that parents should abdicate. It does mean that, with a little diplomacy, understandings can often be reached that meet the needs of all three generations. When you have to say *"No,"* it helps a great deal to be able to make some other suggestion—to think of something a mother or mother-in-law can do that will really be helpful. The friendliness in the family that results from your efforts may be one of the most valuable contributions you can make to your child's future welfare.

No matter how big your family is, the key to its life is the relationship between you and your husband. The more satisfying this is to both of you, the happier and healthier the life of the whole family is likely to be.

Preparing for your delivery

IN the days of our great-grandmothers, women were always delivered at home. Today practically all American children are born in hospitals. Since we have learned from experience that the safest place for the delivery of a baby is a hospital that offers good maternity care, your doctor will almost certainly want you to have your baby in a hospital. He will make the arrangements with the hospital for you. He may do this just after your first visit to him early in your pregnancy, or he may wait until later. Your hospital experience will be more comfortable and have much more in it for you, if you know beforehand what to expect.

Hospital facilities

Some hospitals are glad to show prospective parents as much as they can of their maternity units. Many do not permit such tours. In every hospital, however, there is someone you can see who will be able to tell you what you want to know about the building, admission procedures, the care of maternity patients and costs of maternity care.

Hospitals vary a good deal in the kinds of accommodations they offer, in the services they provide, in the regulations they expect patients to observe, and to some extent, in their charges. Nearly all have private rooms, as well as wards with two, four, or more beds. A room of your own is more expensive than a room you share. If yours is a busy, noisy household, privacy for these few days may be a good investment. On the other hand, you may be someone who likes company and would be lonely in a room by yourself.

Some hospitals do not make reservations ahead of time for maternity cases but all of them register patients in advance. The only room available when you enter may be one that you would not otherwise have chosen. By the next day you can usually get what you want. You will not be in the hospital long unless there are complications. The average stay for maternity cases is about 5 days.

Counseling services

Many hospitals employ one or more social workers—persons trained in counseling who know a great deal about people and their problems, about hospitals and medical practice. If there is one at the hospital where you are going to be, feel free to ask to talk with her about anything that may be concerning you. Expectant mothers who are worried about themselves, their husbands, their children or their finances often find that these hospital social workers can help them to think of ways of solving their problems that might not otherwise have occurred to them. If there is no such person in the hospital where you will be, your doctor or his nurse can put you in touch with the social agency in your

community most likely to be able to give you the kind of help you need.

Hospital expenses

As soon as you can, find out what your hospital expenses are going to be. Know exactly what each item includes, how payment is to be made, and when payments are due. Some hospitals make separate charges for the delivery room, for anesthetics, and for nursing care for you and the baby. Other hospitals charge a lump sum that covers everything. Have a clear understanding about this, so that you will not be surprised, at the end, by bills you did not expect.

You may have hospital insurance, or belong to some group that provides hospitalization for its members. In that case reread your policy carefully, including the fine print, to be sure just what it covers. If you do not have such insurance—and sometimes even if you do—your hospital may require a cash deposit when you enter. This will be subtracted later from your bill. Ask about this in advance so that someone will have the money ready if and when it is needed.

Previewing arrangements

Unless you are regularly attending the hospital clinic, your first contact with the hospital may be when you come for your delivery. Phone your doctor when contractions begin. He will tell you when to start for the hospital. He will also let the hospital know when to expect you.

When you get to the building, you will go first to the admitting office, to check in. Here you will be asked to give certain information about yourself and to sign a contract with the hospital for your care. If your labor is so far advanced that delay is unwise, you will be taken directly to the maternity unit. Your husband or some other member of your family will complete your registration later. The hospital will take charge of any valuables you may have brought with you.

You may wonder why the hospital asks you some of the same questions you have answered for your doctor. This apparent duplication is for your protection. The hospital has taken responsibility for your welfare by admitting you as a patient. It must have in its own records the facts that might be needed to deal with any emergency in your case.

From the general admitting office, you will be sent to the maternity wing or unit. Here you will exchange your own clothes for a hospital gown, and receive your initial preparation for the delivery. Your blood pressure will be taken, a specimen of your urine will be examined and a general check will be made on the stage of your labor. Your blood will be typed and you will be tested for the Rh factor, if these determinations were not made earlier in your pregnancy.

When these preliminaries are over, you will be taken to the labor room to wait until it is time for your delivery. Your labor may be short or it may last for several hours. Some hospitals allow, even encourage, husbands to stay with their wives while they are in the labor room, but many do not. Here again it is important to know the hospital routine. Even if no member of your family is with you, you are not alone. Doctors and nurses will be keeping close track of your progress, and you will probably not be the only patient in the labor room.

From here you will go to a room especially prepared for deliveries. This is where your baby will actually be born. When you first see the equipment in this room you may be reminded of the contraptions in a cartoon. The delivery table has attachments for raising and lowering it, and for changing its angle. It has special devices for holding you in the best positions for delivery, and for

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giving you support where you need it.

There will be other unusual looking pieces of apparatus for the administration of anesthetics and the protection of the baby. Everything in this room has been designed to make each delivery as safe and comfortable as it can possibly be. You will be the only patient here while your child is being born.

After the baby is born

After the birth, the baby will be taken to the nursery and you will be moved to a recovery room, or to your own room. The hospital will make sure that your baby is properly identified before either of you leaves the delivery room. You will be bathed, your uterus will be massaged and your blood pressure will be frequently checked. Someone will be with you until you are fully awake. Where and when your husband will be allowed to see you depends on the regulations of the hospital. He may or may not be admitted to a recovery room.

Most hospitals keep newborns in the nursery and take them to their mothers for their feedings. Mothers are usually encouraged to spend as much time with their infants as the hospital schedule permits.

In some hospitals, mothers have their new babies with them in their own or in small adjoining rooms. This is called "rooming in." If you are interested in this plan, ask your doctor about it. Some mothers like it very much, some would rather not have this much responsibility for the baby for the first few days. As far as the baby himself is concerned, he can get a good start in life either way.

What to take to the hospital

Ask if the hospital has a printed leaflet explaining its regulations. You will want to know who may visit you, what the visiting hours are, what the check-out time is, where your husband will wait, what clothing you will need to take for yourself and the baby.

A few weeks before you expect to go to the hospital, pack a suitcase with the things you will need for yourself. Put it where you can find it in a hurry. Be sure that someone in your family knows where it is. You will probably be wearing hospital gowns during the first day or two after your delivery, but after that you may prefer to wear your own, so take two or three with you. You take your own toilet articles, of course, and a bed jacket, if you have one. The following list is not long but it includes practically everything you will need:

Bathrobe
Bedroom slippers
Bed jackets, 1 or 2
Nightgowns (short) or pajama tops, 2 or 3
Nursing brassieres, 3 or 4
Sanitary belt
Shower cap
Comb, brush, hand mirror
Toothbrush and toothpaste
Simple cosmetics
Box of paper handkerchiefs
Something to read
Fountain pen or pencil
Writing paper and stamps

The hospital will furnish sanitary napkins and, possibly, paper handkerchiefs. You will probably be able to buy newspapers from an attendant. The less you take with you when you go in, the less you will have to bother with when it is time to come home.

The only things you will need to pack, in advance, for the baby will be his going-home clothes. Put into a box or

small suitcase two or three diapers, a shirt, four large safety pins, a wrapper, a sweater, and a cap, a blanket or bunting. It is usually better not to take these things to the hospital with you. Ask someone in your family to bring them to you the day before you and the baby are to be discharged.

The amount of outer covering for the baby will depend on the weather. On a warm summer day the sweater will not be needed and the blanket could be just a light flannel square. If he leaves the hospital on a cold winter day, a newborn will need both a sweater and a heavy outer wrap—a warm wool blanket or a bunting. Some mothers think that babies are easier to handle in buntings with sleeves.

So much for a hospital delivery.

Home delivery

Even though most American babies are born in hospitals, between 30,000 and 40,000 of them are delivered in their own homes every year. If you are pregnant and living where there is no hospital or local doctor, you probably have no alternative to a home delivery. Your first concern should be to find out where you can get reliable medical assistance. If there is a public health nurse in your county, talk with her as soon as you can about this. She will be able to help you in many ways before and after the birth of your baby. If there is no public health nursing service where you live, write to the director of maternal and child health in your State health department in your capital city. Ask for information about doctors, local clinics, hospitals, and nursing services within reach of your home. Also ask for copies of any booklets or leaflets on prenatal care and child development that your State health department may have for distribution.

What you can do to get ready for your delivery at home will depend a good deal on the house you live in and the circumstances under which you live. The people who can help you most with your preparations are the doctor who will deliver you and the nurse who will assist. The doctor will give you a general idea of what he wants you to do and the nurse will work out the details with you.

Try to have everything settled and all the supplies you will need at hand at least three months before the baby is due. This will give you time to check on your setup and to send away for anything important you may have forgotten.

Help at home

Whether you have your baby at home or in the hospital, you will need someone to help you with him or with the housework during the first two weeks or so after he is born, especially if you have other children, live in a 2-story house and are not allowed to go up and down stairs for a while. It may be that your family and friends can give you all the assistance you require, if you plan with them in advance. If not, you may be able to employ someone to come in for a certain number of hours during the day.

Some cities have set up a much needed program called homemaker service. Sometimes this service is under a community agency which has recruited and trained a staff of experienced homemakers to take over in homes where mothers are absent or ill. The agency places and supervises these women who are chosen for their warm and friendly personalities, their skill in homemaking, their common sense, their understanding of emergencies and their ability to fit into other people's family life. There is a fee for their services, but these programs are often partially supported by

It is good to have help

community funds, so you pay only what you can afford. If you have a real need for such help and the service exists in your community, it may be possible for you to have a homemaker substitute for you while you are in the hospital and stay for a few days to help out after you are back in your own home. You can find out whether there is such a service in your town by calling your local community chest, or council of social agencies.

For a while, you may feel a little timid with your new baby, particularly if he is your first one. It may be that a public health nurse could stop by to make sure that you understand the instructions your doctor has given you and know how to carry them out. Or you may be able to engage a nurse from one of the private nursing organizations for an hour or two a day, for a nominal fee. Call your local health department or council of social agencies for information about these services.

There are two final suggestions we hope you will keep in mind as you plan for the coming of your baby: Don't overdo your preparations and do what you have to do as you go along. No amount of hurrying at the last minute can ever take the place of the famous "stitch in time."

Getting ready for the baby

The layette

Your baby will grow so fast that many of the things you get for him now will be too small after a few weeks. Buy as little as you can at first. The stores will be open after he is born! Following is a minimum list of the clothing he will need for about the first six months:

Diapers	4–6 doz.[1]
Shirts (long sleeves, short sleeves or no sleeves, according to the climate)	4
Nightgowns	4
Short kimonos	3
Sweaters	2
Waterproof pants	2
Receiving blankets or pieces of flannel about a yard square	4
Bunting or coat and cap	1

[1] Unless you use a diaper service.

All of these things can be bought or made quite inexpensively. You will begin your collection, of course, by taking into consideration the climate where you live and the time of year your baby will be born.

Diapers should be soft, absorbent, light in weight and not bulky. Be sure to find out whether there is a commercial diaper service available to you that is within your means. It is a great relief to be able to send diapers out for laundering, especially if you do not happen to have a washing machine. You will not have to buy so many diapers if you use a service but even then it is important to have some of your own on hand. Disposable diapers are improving in quality everyday but are not recommended for constant use. They are not as form-fitting as cloth ones and do not always hold the pins as well. For traveling, they are in many ways ideal.

Expectant mothers are usually advised to get infant sizes 1 and 2 for all of the first garments. A very small baby may be comfortable in a 6-months' size for several weeks. When you compare these sizes, you usually find that the only difference between them is in the length.

Nightgowns should be long enough to cover the baby's feet. Some mothers like drawstrings around the bottom of the nighties but these are not essential. Never use them around the neck of any of the baby's garments; they might choke him. Nighties usually open down the back; kimonos and sweaters, down the front. All of these should have wide enough lapovers to make a good closing. Some mothers think that shirts with fold-over shoulders are more convenient. They go easily over a baby's head and do away with the bother of fastenings.

You can use a flannel square or a blanket to wrap your baby in when you take him outdoors but in cold weather

many mothers prefer a bunting because of the hood.

Furniture

It is sometimes a problem for new families or rapidly growing families to decide where the baby should sleep. He will need a quiet place to himself, preferably in a room where he will not be disturbed by household traffic. If he is to sleep in your bedroom, perhaps you can arrange the furniture to give him a corner of his own. A wardrobe or bureau can sometimes be moved out to make a partition. Some parents use a sturdy, folding screen. Within a few weeks, you will want to have him sleep somewhere else so that all three of you may have more privacy.

Furniture for babies can be very simple. You and your husband can make most of it, if you are handy with tools and have the time. The first bed may be a strong basket or box, softly lined, or a bassinet. A basket with handles is convenient because you can pick it up and take the baby almost anywhere in it. A bassinet on wheels can save you many steps as you move it from place to place in the house but be careful of collapsible legs. Always be sure that a basket or box is sitting squarely on something strong and steady.

A word should be said here about the paint to be used on toys, baby furniture, and the walls and woodwork of the baby's room. Paints with more than 1 percent of lead in them are unsafe for children. Those intended for indoor use contain ***less*** than 1 percent of lead. Look closely at the label on every can of paint you buy. If it says "Manufactured for indoor use," or "Conforms to American Standard Z66.1—1955 for use on surfaces which might be chewed," you are all right. Most furniture and toys that have their original coatings are safe in this respect because manufacturers are usually careful about the paints they use on anything intended for children.

After the first two or three months, your baby will need a crib, so you may prefer to have him sleep in one from the beginning. Choose one with bars close together so that he cannot get his head caught between them. It is not safe to take the baby into your own bed for sleeping.

A table for bathing, changing or dressing is almost indispensable. If your space is limited, you can put up a broad shelf that can be dropped against the wall when not in use. Whether you use a table or a shelf, the working surface should be at a height you can reach conveniently, without stretching or stooping.

You will need a chest or separate drawers for the baby's clothing and supplies. You will also need a rust-proof pail with a cover for holding diapers. Diaper services supply their own. You and the baby will both be more comfortable if you sit on a low chair with a footstool when you feed him.

Bedding

For the mattress in a bassinet or basket bed, use only a smooth, flat pad. This can be made at home out of a folded cotton blanket or quilted mattress protector. The baby will not need a pillow and is better without one.

A crib must have a firm mattress and a spring that does not sag. These must both fit snugly, so that a squirming infant will not be able to catch a hand or a foot between the mattress and the sides of the crib.

Here is a list of bedding you will need. You can make most of it, if you wish, by cutting up partly used household sheets and blankets.

Rubber or heavy-gauge plastic sheets big enough to

tuck under on both sides of the crib mattress, if this is not plasticized	2
Pads about 18 inches square to put under the baby. These may be quilted cotton or a synthetic material	5 or 6
Crib-size sheets. The fitted knit ones are very convenient. A pillowcase makes a good sheet for a bassinet	4 to 6
Thin, crib-size blankets of wool, cotton, or synthetic fiber, depending on where you live and the time of year. Some mothers especially like the baby sleeping bags now on the market	1 2 or 3

Never use lightweight transparent plastic bags anywhere near the baby's bed. If this thin plastic gets over the baby's face, it can stop his breathing.

Bath supplies

To be able to bathe the baby conveniently, you will need the following supplies:

A plastic, or rubber bathtub, unless you intend to use the bowl in the bathroom or the kitchen sink.	
Soft towels	2 to 4
Soft washcloths	3
Bath towels big enough to cover the bath table	2
Absorbent cotton, or cotton balls in a covered jar or can.	
Rustproof safety pins.	
Baby lotion or plain mineral oil; a small, flat dish to hold a day's supply of the latter.	
Soap and a soap dish. (Any mild unmedicated soap will do.)	

Fitted trays for bath supplies are nice but can be very expensive. Baby supplies usually come in bottles or jars, so you may not need to provide your own containers for such items as soap, cotton balls, oil, safety pins, etc. If for some reason you would rather set up a tray, this is easy to do. A flat enamel baking pan or oven tray with low sides will do to hold things. You probably have, in your own kitchen, screw-top jars of different sizes. These should be washed and boiled before you put anything for the baby in them, and frequently after that.

Feeding equipment

Until you know whether or not you are going to nurse your baby, do not lay in a large supply of bottles and nipples. Even if you breast feed him, however, you will need two or three nursing bottles with extra nipples for giving him his fruit juice and boiled water. You will probably need:

A sterilizer.

If it works properly, a secondhand one will do just as well as a new one.

If you want to improvise a sterilizer, you can use a covered kettle or deep saucepan large enough to hold a rack with 6 or 8 bottles in it.

Nowadays most mothers make up the formula, pour it into the bottles and boil these for 25 minutes in the sterilizer or covered kettle. This is called "terminal sterilization." There are other methods but this is probably the most common.

Long handled forceps or tongs for lifting the bottles and nipples out of the sterilizer.

A covered jar for extra sterilized nipples.

A bottle warmer.

You will keep the bottles of formula in the refrigerator, so you will need some way of warming each feeding as you use it.

Some mothers simply heat the bottle in a pan of water. Most drugstores have electric bottle warmers for sale, and some are quite inexpensive.

Equipment for fixing fruit juice.

A measuring cup, a funnel, a spoon, and a shaker for the concentrated varieties.

Everything you use for the juice should be made of materials that can be sterilized.

Many doctors now prescribe ascorbic acid tablets for babies instead of orange juice. When orange juice is given, it is usually frozen or canned.

If you want fresh orange juice, you will need, in addition, a squeezer and a strainer.

Many young couples enjoy getting these things together. Nothing that you buy needs to be elaborate or expensive.

Your baby and his family

THE 3-year old who pinches her baby brother, the 4-year old who shouts "Take him back, Mother. I don't want him," are not fictional characters invented by people who write about children. They are real youngsters, to be found in almost any neighborhood where there are young families. They are small fry who consider themselves displaced persons and don't like the feeling.

How babies change family ways and feelings

So much attention has been paid to the problems of these children, we sometimes overlook the fact that everyone in a family is affected by the arrival of a new baby. Family ties are deep and strong. We depend on them for our basic security. We love and are loved by other family members. We get used to certain family relationships and routines. Along comes a baby, and the whole setup changes, both physically and emotionally. Someone may have to share his room. Two people who have spent a great deal of time together may now have to give up some highly prized hours of companionship.

These usually turn out to be adjustments, not real sacrifices. The baby is finally settled in, feelings are sorted out and the family continues on its way. While these adjustments are taking place, there are steps that can be taken to make things easier for everybody.

Family members of different ages react differently to family changes. This is because these changes have different meanings for the old and the young.

Grandparents, for instance, are often more fearful and set in their ways than we realize. They have fewer pleasures than when they were young, fewer activities, less to look forward to. They may hope to meet some of their emotional needs by devoting themselves to the baby. The many who live with married sons or daughters may worry for fear the baby will upset their living arrangements. When these older family members have a chance to help make the family decisions that affect them, they are much happier and their suggestions are often extremely good.

A father may be proudly looking forward to parenthood, but dislike the inconveniences caused by his wife's pregnancy. He may think that babies are lovable in principle, but not so nice when they cry in the night, soil their diapers, and tie their parents to the house in the evenings for weeks on end. If he is like most expectant fathers, he will feel differently when he gets to know his baby. Meanwhile, it helps if he knows that his family understands.

Brothers and sisters

Most older brothers and sisters take new babies in their families in stride. They appreciate it when parents share the news with them before outsiders know it. They usually join eagerly in family discussions about what has to be done to get ready for a baby. If you have adolescents in your family, you know how important it is to think with them, not for them. It may take time for a high school freshman to get used to the idea of doubling up with a 6-year-old. Once he feels that he has a real part in the planning, he will usually go with you all the way, as long as what you ask of him seems reasonable to him.

With younger children of school age the situation is different. They are apt to be intrigued with the idea of having a new brother or sister. They are close enough to babyhood to appreciate a baby's need for gentle care. The older ones have exciting interests of their own to which a baby as yet offers no competition. The 6 to 12's may have their jealousies and resentments, but a little extra attention from mother or father usually brings back the feeling of being loved and wanted.

The 3- to 5-year-olds have their own special needs. They are "big-little" children and it is easy to treat them as if they were more grownup than they actually are. They may begin to notice that their mothers and fathers spend less time with them now than they used to, and ask them to do more for themselves. When the baby actually comes into the family, they may feel still more lost. Parents who understand these feelings, can find many ways of convincing these older preschool children that they are permanently and deeply loved.

Your toddler is the person in your family most apt to feel really displaced. He is still a baby himself. He is used to being in close contact with you most of the day. You help him to get dressed, you help him with his meals and with his play. Now when he wants you, you are often too busy to stop to listen, tell a story, play a game or wipe away a tear. It may be that these 1½- and 2-year-olds are more in need of reassurance during a pregnancy than any other children. The jealousy they sometimes feel is a very natural human reaction. However, these feelings can usually be overcome by parents who know how to be comforting.

Introducing the baby to his family

There is no one best way of introducing a baby into his family. Experience has shown, however, that some ways of preparing the family for his coming

a family project

seem to have better results, in the long run, than others. Here are a few suggestions:

1. Make it clear that this baby will belong to his whole family, not exclusively to any one person in it, even his mother. Think and speak of him as "ours," rather than as "mine" or "yours."

2. Tell the grandparents that he is coming as soon as you and your husband are ready to share this information. Let them know that you realize how much this means to them, that you appreciate their concern, and will count upon their help when you need it. If you feel that you need to protect yourself against "interference," you can do it better this way than by setting up barriers to begin with.

3. Take your teenagers into your confidence almost at once. They can be a tremendous help if you give them responsibility.

4. Tell your school-age youngsters at about the time your pregnancy begins to show. It is probably better to wait until later to talk with your preschool children. A long period of suspense is not good for 4- and 5-year-olds, who are not too clear about what it all means, anyway. You may decide not to tell the very little ones until it is almost time for you to go to the hospital.

5. Plan with the family as much as you can. We all cooperate better if we know what is happening to us and have something to say about what is being done.

6. Be ready to let the children help with the preparations, in some way, as soon as you tell them. Later the baby will seem less of a competitor if you give them the feeling, from the beginning, that getting ready for him is a family project. Where will he sleep? What will he wear? Where will we keep

his clothes and things? Everyone, except the ones who are too young to know what is going on, will have ideas about these questions and some of these ideas will be very good.

When people treat important family events as matters of common concern, an atmosphere of mutual confidence and respect grows up in a home. It is by living in such an atmosphere that we get our individual security as family members. Knowing that we are loved and trusted by those who are dearest to us, we can usually overcome, without too much trouble, the feelings of discouragement that everyone has now and then.

Reassuring the young child

If you have a young child, here are some specific things you can do to help him look forward with pleasure to the coming of the baby:

1. Wait, if you can, to tell him the news until you have a sign from him.

   The 2 to 3's will probably notice your change in shape. Sometimes you may catch a puzzled look, sometimes a small hand will pat your enlarging abdomen.

   Most 4 to 5's are already beginning to wonder where babies come from. Yours may be asking questions now.

   If your child does not seem to be noticing anything different about you, and is not asking questions, you will soon want to look for a way of bringing the matter up. Having a new baby in the family gives parents many natural opportunities to give simple, factual information to their children that will be a good foundation for more advanced explanations later on.

2. Don't try to tell your child more than he wants to know. What you say will depend on his age, his questions and your feelings about his sex education.

3. Be casual when you talk with him about the baby. He will only be upset if you make the whole thing seem mysterious.

4. Make any necessary physical changes in your home setup ***before*** you go to the hospital, so that these will not be too closely connected with the new baby when he comes home.

   If a child under 3 is to be moved from his crib to a junior bed, or to another room, try to move him two or three months in advance. Without making too much of it, help him to be pleased with the change.

   You can seldom get a toddler's cooperation by telling him how grown-up he is with a bed or a room of his own. Because he is still in many ways a baby, he often needs to be treated like one. But he still can be helped to feel that there are privileges and rewards that come with being older. It doesn't help to keep telling him that you love him, unless you show him that you do.

5. Prepare him for your absence by telling him that you will be going away but that you will be home again in a few days.

6. If the person who is going to look after the family during your absence is a stranger to your children, have her come a few days before you leave for the hospital. If this is not possible perhaps she can visit for a few hours at your home. It is important for the children to know and like her.

   A father is a particularly important person at this time. He may want to consider arranging his work so that he can take a few days vacation at home while you are in the hospital. Small children, especially, need the reassurance of his presence and attention.

7. Keep up some sort of contact with the children while you are in the hospital. Your stay will be short but may seem long to a young child who is used to having his mother around all the time. No hospitals allow young children to visit on their maternity floors, but perhaps you can talk with yours once or twice on the telephone or send home a note just for them. Not too often. One call or one letter may be enough to give the reassurance that is needed; too many might undermine confidence in the person who is taking care of the family.

8. Pay careful attention to the next oldest child when you bring the baby home. It may be a good idea to have your husband carry the new baby into the house, so that your arms will be free for your toddler.

   Be prepared for the fact that your 2-year-old may ignore you, at first, or seem fussy and restless. The feeling of strangeness he has now will disappear shortly, if he is naturally a happy child. His feelings of jealousy will not last long, or may not show until later, when the baby really gets in his way.

   It is usually a mistake to punish a child for expressing his ugly feelings. They are better out than in. If he acts them out by hitting or shouting or throwing things, these actions, of course, have to be curbed. Seemingly, the best way to help a child who is really jealous of a new baby is to give him many happy experiences with the rest of his family. This is how most children build back a sense of inner security if theirs has been disturbed.

   If you have someone to help you, it may be a good idea for you to let her assist you with the baby, so that you may have more time for your toddler. Be sure that his playthings, his playspace, and his sleeping arrangements are not suddenly disturbed. Give him time, play with him, rock him a little before he goes to sleep.

9. It will not help to act as if the baby were not there. Even a 2-year-old knows that there is something very important to you in that crib. It is better to try to help him accept the new baby in small doses from the start.

   You will, of course, be cautious about these contacts for a while. Little children do not know how to play with babies until they have learned what they may and may not do with them. Without really knowing what he is doing, a small child can hurt a baby.

   One has to be gentle and patient with this kind of teaching. "Let me show you how to hold him," ***not*** "Don't you touch him! Leave him alone!"

In spite of all that has been written and said about bringing new babies into families, the fact remains that babies and their families always have to find each other in their own ways. It is true, however, that families and babies thrive best when the coming of a baby is really a family affair.

Some usual discomforts

ALTHOUGH a normal pregnancy can bring you a great deal of satisfaction, certain discomforts may be connected with it. These are not serious but if any of them bother you, do what you can to counteract them. It is not good for you to be uncomfortable if you can help it. If you have a discomfort that is not mentioned here, ask your doctor what you can do about it.

Fatigue

During the first three or four months, many pregnant women complain of being tired. Fatigue is natural in the early stages of a pregnancy. Your body is getting accustomed to the many complicated changes taking place within it, and the many new demands being made upon it.

Nature's way of taking care of at least some of this exhaustion is to make you sleepier than usual, so you get more rest. This sleepiness disappears as you make the necessary physical and emotional adjustments to your pregnancy. The best way for you to cope with this discomfort is to get plenty of regular sleep at night and take the rest prescribed for you during the day.

Frequent urination

Soon after your pregnancy begins, you will notice that you are getting up at night to urinate and that you need to empty your bladder more often than usual during the day.

The reason for this is simple. Your bladder is normally located just in front of your uterus. When the uterus starts to enlarge, it may put pressure on the lower end of the bladder. This makes you feel like urinating, even when there is hardly anything in the bladder to void. This condition is normally relieved after about the fourth month by a change in the position of the uterus. In the last month of your pregnancy when the baby moves down to get into position to be born, you will again be feeling the urge to urinate more frequently. Since a cough, a hearty laugh or a hard step down may cause the bladder to leak a little, some women regularly wear a sanitary napkin for protection.

There are times when frequent urination is more than a discomfort. If the urge to urinate is extreme, and if you have pain or a burning sensation when you do, report this to your doctor. He will want to find out what may be causing the difficulty.

Food cravings

Pregnant women often experience cravings for certain foods. These may be due to physiological disturbances not directly connected with food, or they may be a sign of emotional disturbance. They are not a necessary part of pregnancy and should not be confused with

normal food likes and dislikes.

If you are bothered by an extreme desire for a certain kind of food, talk with your doctor about it. He may want to go over your entire food plan with you to spot weaknesses or excesses in your diet. He may ask you to keep an accurate record of everything you eat for a week or two in order to obtain a picture of what you consume. With this information, he will know better how to advise you. Food you do not need may upset your weight gain. If your diet is too restricted or otherwise inadequate, you will need more of certain foods. It is a fact that most women who have had a balanced diet before they become pregnant do not have intense cravings if they continue to eat the right foods during pregnancy. (See pp. 13–22.)

Mouth watering

Occasionally, a pregnant woman finds that her mouth is watering more than usual. We do not know why this happens. The flow of saliva usually becomes normal again after a while without any special treatment. Excessive salivation is unpleasant, but not serious. It sometimes helps to chew gum or to eat several small meals rather than fewer larger ones. If this is really a problem to you, consult your doctor.

Morning sickness

Today, most expectant mothers have little trouble with "morning sickness." As your body gets used to the changes of pregnancy, any feelings of nausea you may have should disappear. This "sickness" is not confined to the morning hours, by the way. It seldom lasts longer than the third month. Avoid vomiting if possible and never encourage it. If vomiting should persist and you cannot keep fluids down, see your doctor immediately.

If your trouble is just a sickish feeling when you wake up, there are several simple things you can do for it. Starving yourself will do no good, because this kind of stomach upset is relieved by food. Try eating some dry crackers before getting out of bed. Don't take a drink right away; liquids often make matters worse. Get out of bed slowly and move slowly for several hours. Brush your teeth gently or don't brush them at all until later in the day. Don't try to make beds or do dishes until you feel better. It may help to eat four or five dry meals a day instead of the usual three, taking fluids only between meals. These must be counted, however, in your total daily food allowance. There are many drugs available now for the relief of "morning sickness." Your doctor may want you to try one of these medicines.

Heartburn

During the last three months of pregnancy, the growing baby presses up against the stomach and may interfere with the normal movements of digestion. The result may be a pain in the chest which is near the heart but has nothing to do with the heart at all. It is a form of indigestion, commonly called heartburn.

There are medicines that help this pain. Tell your doctor if this is a problem to you. **Never take baking soda unless your doctor advises you to do so.**

Constipation

If you are bothered by constipation, there are things you can do about this, too. Work out a routine for yourself that will keep your bowels working as naturally as possible in their normal rhythm. For some people, this means movements only every other day, or every

two or three days.

To prevent constipation, doctors usually advise their patients to get plenty of exercise, eat plenty of fruits and vegetables and drink plenty of water. Some recommend two glasses of water before breakfast. Prunes are a natural laxative and may be taken raw, stewed, or in the form of juice. It may help to put your feet up on a stool or low waste basket when you sit. This gives you a better body alignment. Try to go to the bathroom for a bowel movement at the same time each day, preferably just after breakfast.

If you do become constipated, ask your doctor what to do about it. He will tell you not to make a habit of taking laxatives. These keep the bowel lining irritated, and prevent the formation of good habits of elimination. He will also warn you to avoid harsh laxitives, such as castor oil and Epsom salts. These are likely to upset your stomach and cause cramps in your lower abdomen. If yours is a stubborn case, your physician may prescribe a tablespoonful of milk of magnesia to be taken each night before going to bed.

Hemorrhoids

Hemorrhoids are small groups of enlarged veins located at the lower end of the bowel. They are often called piles. Many people have them but they are more common in pregnancy because of the pressure of the baby on the veins of the lower part of the body. A little petroleum jelly placed just inside the rectum before a bowel movement may make it easier for the stool to pass and, therefore, unnecessary for you to strain.

Straining may squeeze hemorrhoids out of the bowel opening. They are often painful anyway, and this makes them more so. If this happens to you, your doctor can show you how to wrap a piece of cotton around your finger and push them back in again. Lie down on your side, with your hips on a pillow and use mineral oil or petroleum jelly to lubricate your finger.

A compress made of a few folds of clean gauze soaked in ice-cold witch hazel or a solution of Epsom salts will relieve the discomfort. If your hemorrhoids bleed, as some do, let your doctor know.

Muscle cramps

During your pregnancy, you may be bothered by cramps in the muscles of your legs, and in the wall of your uterus.

Leg cramps are often due to a slowing up of the blood circulation in the legs because of the pressure of the baby in the uterus on the large blood vessels in the lower part of the abdomen. This usually happens when you lie on your back. If this is the cause, you may be able to get relief by rubbing your legs gently, by bending your foot upward with your hands, or by putting a hot-water bottle against the muscles that are cramped. To avoid leg cramps of this kind, "point with your heels and not your toes" whenever you stretch your legs.

Sometimes leg cramps are due to nutritional deficiencies, particularly to lack of calcium and certain vitamins. Your doctor will look into this possibility as a matter of course and prescribe supplementary calcium and vitamins, if you need them.

Cramps in the uterus are common throughout most of pregnancy. They are due to contractions of the muscles of the uterus. They usually go away if you take a short rest. If they persist or become increasingly uncomfortable, your doctor should know about them.

Backache

Backache is often relieved by changing to shoes with medium or low heels if

you have been wearing higher ones (see p. 25). A well-fitted girdle may also help. Your doctor may prescribe exercises to improve your posture (see p. 22 and p. 68). Ask someone to give your back a good rubbing now and then.

Varicose veins

Varicose veins are enlargements of the veins lying just beneath the skin. They occur most frequently in the veins of the legs, although some people have them in the form of hemorrhoids (see p. 51). Some women get them more easily than others. They usually get smaller and disappear during the first few weeks after delivery. Consult your physician if you have some that are giving you trouble.

Doctors know what causes varicose veins but are not always able to prevent them. The leg veins empty into the large blood vessels in the lower part of the abdomen. During pregnancy, pressure of the baby on these large blood vessels slows up the circulation of blood in the legs and may cause varicose veins to develop or get worse. It is important to take proper care of these enlarged veins because they can become quite painful. If you sit with knees slightly bent and your legs not crossed, you will be more comfortable.

Frequent rest periods with your feet up may help to arrest the swelling of the veins, perhaps even to reduce it. You may need to wear an elastic bandage or stocking during the day. This should be removed at night. You can get attractive elastic stockings now that hardly show under thin hose. Your doctor or the nurse in the clinic will show you how to wear these properly. Put these on before you get up in the morning, before your legs' veins have a chance to fill. If you use an elastic bandage, be sure to wrap it once or twice around your instep as you put it on. This will anchor it, and keep your foot from swelling. If you wear stockings, do not keep them up by rolling them tightly either above or below your knees. Do not use round garters.

Some pregnant women have an enlargement of the veins around the vulva, the vaginal entrance. This condition is more common after several pregnancies. It also is due to the pressure of the baby in the lower abdomen and will probably disappear after the baby is born. No treatment is usually necessary although rest or a tight T-binder may help to relieve discomfort.

Vaginal discharge

During pregnancy, the tissues of the vagina change in preparation for the baby's birth. The lining becomes softer and thicker and more elastic. At the same time, the glands in the cervix increase their normal production of mucus in order to lubricate the vaginal passage. This mucus is the slight, whitish, sticky discharge from the vagina that most pregnant women notice. This discharge should not inconvenience you. If it stings, burns or itches, check with your doctor.

Changes in the skin

You may have noticed that little red streaks have appeared on the skin of your abdomen or breasts. These are due to the stretching of the skin and are not serious. They will fade into thin white lines after the baby is born.

Another change sometimes takes place in the skin that worries some women more than the streaking. It occasionally happens that blotches appear on the nose and on the breasts. For a while these may be rather unsightly but there is nothing abnormal about them and they usually vanish promptly after childbirth. There is nothing to do but put up with them while they last. Brunettes have

them more often than blondes. Exposure to the sun makes them worse.

Shortness of breath

In the last month or two of pregnancy, you may be a little short of breath when you climb stairs or engage in certain activities. This is probably because the baby is taking up enough space in your abdomen to interfere with your breathing. This is usually a temporary discomfort, something that goes away as soon as the baby is born. The best way to handle it is to move more slowly, avoid stairs when you can, and practice deep chest breathing. Be sure to tell your doctor if breathing becomes difficult while you are lying flat.

Some possible complications

The importance of symptoms

Although minor annoyances are fairly common during pregnancy, serious problems seldom arise. These rare conditions are known as complications of pregnancy. Most of them can be prevented. This is why it is so important for you to go to your doctor when you first suspect that you are pregnant and remain under his care until your baby is born.

Complications which might endanger you or your baby if they were to go undetected or untreated almost never appear suddenly or unexpectedly. Usually one or more warning signals occur in advance. Your doctor will watch for these signals or symptoms on each of your prenatal visits to him. Some can be detected during your regular physical examinations; others in the results of such simple tests as blood pressure readings, blood counts, blood typings, urine analyses, and checks on your weight. (See pp. 5 and 7.)

Some symptoms may develop that you will be the first to notice. The most important of these are bleeding from the vagina, however slight; severe or continuous nausea and vomiting; continuing or severe headache; swelling or puffiness of the face or hands, or marked swelling of the feet or ankles; blurring of vision or spots before the eyes; a marked decrease in the amount of urine passed; a several pounds weight gain in a 1-week period; pain or burning on passing urine; chills and fever; sharp or continuous abdominal pain; sudden escape of water from the vagina.

Symptoms to be reported

Your doctor will give you special instructions about symptoms that should be reported to him without delay. Let

him know right away if you have any of these symptoms or others which may mean that trouble is brewing. In this way, early treatment is possible and most difficulties can be avoided. Unless accompanied by one or more of these symptoms, none of the vague complaints or discomforts that may trouble you is likely to be of major consequence.

Such symptoms may or may not be significant, depending upon the circumstances under which they occur. Nevertheless, your doctor will want to know about any you have so that he can evaluate each one in the light of your particular case, even though it may not prove to be a cause of concern. For instance, slight bleeding during the first two months of pregnancy at the time a menstrual period would ordinarily have occurred, does not usually mean that you are about to have a miscarriage. Later in a pregnancy, recurrent lower abdominal pain, slight bleeding and a discharge of water from the vagina may simply indicate the onset of normal labor. In general, however, you should notify your doctor of the appearance of any of these symptoms as soon as possible. It is important for you to keep every appointment to see your physician so that he may inquire into the circumstances of any symptom or problem, decide whether or not the complaints are real danger signals, and give you treatment, if needed, at the earliest possible time.

Illnesses

Illnesses strike infrequently during pregnancy, because most young women of childbearing age enjoy good general health. It is also true that, except for a few complications most problems related to childbearing occur only once in several hundred births. This is why pregnancy is generally regarded as a normal process and one that is a happy experience for most women. Even so, to overlook the occasional problems that may arise or to neglect your responsibility of seeing to it that your doctor has ample opportunity to detect and treat them promptly would be a mistake. To help you meet this responsibility, the following pages will acquaint you with abnormal conditions which might occur during pregnancy and give you sufficient information so that you can report important signs and symptoms promptly to your doctor.

Miscarriage

The term "miscarriage" refers to the birth of the baby at a time before it has developed enough to live in the outside world, usually before the fifth month of pregnancy. At least 1 pregnancy in 10 comes to an end in this manner. About two-thirds of these occur in the first three months.

Miscarriages may be due also to factors other than abnormalities of the egg or infant, and many of these may be discovered and treated successfully before the next pregnancy occurs. Moreover, it should be understood that the chances for success in the pregnancies following one miscarriage are very good, because the cause usually does not recur. You should not count on this, however, and you should allow yourself to be checked for problems that persist. Miscarriages due to glandular or nutritional problems can sometimes be avoided by good prenatal care, but the best hope is to have these conditions studied and treated by your doctor before you undertake another pregnancy.

Miscarriage used to be blamed on a fall or blow to the abdomen, but doctors now know that this is an exceedingly rare cause. The baby is protected within a sac of fluid in the uterus and usually escapes injury even in the event of a serious accident to the mother.

A pelvic examination by your doctor will not cause a miscarriage. It is neces-

sary for him to examine you thoroughly at the beginning of pregnancy, even if there is bleeding. Often the bleeding is not coming from within the uterus, but arises from conditions in the mouth of the womb, the vagina, or elsewhere. In very rare circumstances, the pregnancy may be found in the tube rather than the womb. This is another reason for having a careful examination, even though you may be bleeding at the time.

Treatment of a miscarriage

Slight bleeding may mean that a miscarriage is only threatening and that the baby may yet be saved. More severe bleeding, especially with cramps, usually means that a miscarriage is actually happening. The doctor will want to know if the mouth of the womb is opening, indicating that loss of the baby is very likely to occur. He can make this judgment only if he does a pelvic examination. If he finds the mouth of the womb closed, the outlook is much more favorable, and he may prescribe bed rest and other measures to prevent the miscarriage. If, on the other hand, he finds that some tissue has already been passed, he may advise scraping of the womb, commonly called a D&C (dilation and curettage), to remove the remaining bits of "afterbirth" (placenta) in an effort to stop bleeding and prevent infection.

If you notice bleeding at any time during pregnancy, go to bed at once and have someone notify your doctor. He will want to know when bleeding began, how much bleeding there is, whether or not you have passed clots or tissue, and whether or not you have had pain or cramps in your abdomen. You should save all clots and tissue for the doctor so that he may look for pieces of the afterbirth. The finding of tissue in the material you have saved may influence his treatment.

Miscarriages which start of their own accord and are managed promptly by the doctor are rarely dangerous to the mother, and recovery is usually rapid. On the other hand, miscarriages brought about by illegal means, either self-induced or carried out by some illicit practitioner or midwife, are often disastrous because of infection, severe hemorrhage or puncturing of the womb.

A miscarriage deliberately caused by entrance of unsterile instruments or other unclean objects into the uterus, or done by an unqualified person, can lead only to a grave risk of death to the mother. Even if she escapes death, she may require prolonged hospitalization to combat shock, infection, and abscesses in the pelvis. She may also lose her ability to bear children.

Therapeutic abortions

Occasionally it may be necessary for medical reasons to stop a pregnancy. If this decision is made, the operation must be done by a qualified doctor with the advice and consultation of several other doctors. These miscarriages, called "therapeutic abortions" by doctors, can be safely performed only in the operating room of a hospital under the strict, sterile precautions required for all other surgical operations. However, medical advances have made it one of the rarest operations performed today.

Prolonged vomiting

Mild nausea and vomiting, usually in the morning, are common complaints, but prolonged and persistent vomiting is an unusual complication. This complaint should be reported to your doctor immediately, especially if you are unable to keep down fluids; and it may be a problem of special concern if it comes on suddenly after the third month of pregnancy. If abdominal pain is present with

vomiting at any stage of pregnancy, your doctor should be notified at once. Although the problem may be due to a virus or a temporary intestinal upset, your doctor should evaluate the symptoms in the light of your individual circumstances. Rarely, there may be an obstruction of your bowel or other serious problems requiring immediate treatment.

Although few women experience prolonged vomiting, it may occur in the absence of disease in some "high-strung" mothers with serious personal or family worries. Talk with your doctor if anything is troubling you. He may be able to help straighten things out or arrange for you to talk to someone who can give you the kind of assistance you need.

Toxemia of pregnancy

Toxemia is a complicated disorder which may be associated, in its extremely advanced stages, with high blood pressure, marked swelling, marked weight gain, albumin in the urine, and symptoms of headache, dizziness, blurred vision, spots before the eyes, nausea, vomiting, pain in the abdomen, and, in rare cases, convulsions and coma. The important thing to remember is that in the early stages no harm comes to the mother or her child if the condition is properly treated.

This is why your doctor will ask you about swelling of your face and fingers, rapid weight gain, and any persistent headaches or eye symptoms. Likewise, it is understandable that he should emphasize diet, salt restriction, and adequate rest, if you begin to show any of these danger signals.

If you report for your checkups faithfully, the trend of your weight, blood pressure, and urinary findings may point up the need for restrictive measures before you are in real trouble. The doctor may even want you to go into the hospital for special care although, as far as you can tell, you may feel perfectly well. Most of the time, corrective home measures will suffice, if you are cooperative in carrying out your doctor's instructions at the earliest sign of trouble.

Certain conditions increase the likelihood of developing toxemia and may lead your doctor to give you special care throughout pregnancy. He may ask you to report for checkups more frequently than you had expected. You should not be alarmed by this, because your doctor is trying to see to it that your pregnancy proceeds normally. This may be the case if you are known to have had toxemia previously or if you have high blood pressure when you are not pregnant. Patients with diabetes, kidney disease or heart trouble are entitled to this special consideration.

The two most serious dangers in toxemia are death of the baby before birth and the possibility of the mother's developing convulsions or "eclampsia." These complications are much less common today than they used to be, because most patients now receive good prenatal care. They are more likely to develop in the women who do not have the benefit of good prenatal care or who do not heed the advice of their doctor. In moderately advanced cases of toxemia, the doctor now has available certain drugs to lower the blood pressure and to ward off convulsions. Even these treatments are unnecessary, if the earliest signs are noted and simple precautions are taken. After the birth of the baby, the mother's circulation and kidney function usually return to normal.

Urinary infection

A pregnant woman is somewhat more likely to develop an infection in the bladder or kidney than one who is not pregnant. Certain changes in the urinary tract occur in pregnancy that hinder proper drainage of urine and make it

susceptible to infection. These infections are serious only if they go unrecognized and proper treatment is not given early in the disease and continued until a complete cure is achieved.

The usual early symptoms of bladder infection are burning on urination, and an urge to urinate often. The urine may be cloudy or tinged with blood. There may also be a low-grade fever and chilliness.

When the kidneys are involved, a series of sharp elevations and drops in temperature may occur within a few hours, usually to a higher level than that noted in bladder infections, sometimes as high as 104°. The fever is often accompanied by shaking chills, backache, and tenderness in the back at the junction of the last rib with the spinal column.

If you notice such symptoms at any time during pregnancy or after you have returned home following the birth of your baby, call the doctor, go to bed, and drink plenty of water. The doctor will be able to prescribe a drug that will clear up this infection and make certain that it does not linger on in mild form to cause permanent damage. Even though you may no longer have symptoms following a course of treatment, your urine will need to be checked to be certain that all the bacteria are dead.

Anemia

Anemia is a condition of the blood resulting from a reduction either in the number of red blood cells or in the amount of hemoglobin. Hemoglobin is the red colored substance in the red blood cells which carries oxygen to the body tissues. If the amount of hemoglobin is below normal, or if there are too few red blood cells, not enough oxygen will get to the tissues. In pregnancy, it is particularly important to prevent anemia, since both the mother's body and the baby need a good supply of oxygen.

Anemia may develop from loss of blood or from a lack of sufficient iron in the diet. Iron and protein are important materials for forming hemoglobin. Lean meats, especially liver, and eggs are good sources of iron and protein. A pregnant woman may become anemic, because it is often difficult for her to get enough iron from food alone to take care of her own and her baby's needs. The baby must store iron during the months before birth so that he will have enough to carry him through the early months after birth before he can take solid foods. Often some kind of iron compound, in the form of pills or capsules, will help to supply the extra needed during pregnancy. Your doctor can decide about this by checking the amount of hemoglobin in your blood from time to time.

Some types of anemia in pregnancy are due to more complicated causes and may be harder to treat. Fortunately they are much less common.

Premature birth

Birth of the baby before it has reached a weight of 5½ pounds is referred to as a premature birth. It occurs in only about 10 percent of all births that go beyond the fifth month. Because these small babies are not as strong as full-term ones, they must be given special care immediately after birth in order to live.

Premature birth is ordinarily not a great problem among healthy, well-nourished mothers. Those who are malnourished or suffer from some chronic illness are more susceptible. It occurs more frequently in twin pregnancies than in single births. Usually, in these circumstances, these babies are relatively mature in spite of their small size and may be expected to do better than a single baby of the same size. In other cases, early birth occurs as a result of syphilis, toxemia, or other serious prob-

lems; but this risk is much less when proper treatment is given early.

Many premature births may not be associated with obvious disease. It is important, therefore, for you to think of this possibility when crampy, labor-type, rhythmical, abdominal pains develop. If these persist for a period of time, you should report them to your doctor, even though in most instances it will be part of the normal contracting action of the womb. A sensation of tenseness in the womb may be a frequent occurrence in the last weeks before your baby is due. When you are resting quietly or you have been under an emotional strain, these contractions may be more noticeable. If you have doubts about their true nature, you should notify your doctor.

A sudden gush of water from the vagina several weeks before the baby is due usually means that premature birth of the baby is likely. The gush of water results from breaking of the bag of waters and is often the first sign of premature labor. In this instance, you will continue to drain fluid even though your bladder is empty.

If the bag of waters breaks, let your doctor know at once. He may want you to come to the hospital to await labor even if it has not yet started. Under no circumstances should you take a tub bath or a douche, or otherwise allow contamination of the birth tract, because the protective bag of waters is lost, and bacteria may spread directly to the baby from the vagina and lower tract.

Rh factor

Your doctor checks your blood type routinely as a precaution in case you need blood during pregnancy or delivery. In addition, he determines the presence or absence of the Rh factor—a substance which is present in the blood cells of a large proportion of people. This factor is found in the blood of about 85 percent of white women and in about 95 percent of Negroes. This factor is a matter of concern only if it is ***absent*** in the woman while being ***present*** in the husband's blood. In these "incompatible" couples, the infant, who may inherit the factor from the father, may cause the mother to develop antibodies against this factor. These substances (antibodies) are manufactured by the mother as her protection against new materials introduced into her blood—in this case it is the baby's red blood cells which contain the Rh factor she does not possess.

Ordinarily, the first baby who causes this reaction in the mother will not be affected by the mother's antibodies. If the mother has already developed these substances before her first pregnancy as a result of a transfusion with Rh positive blood, even the first baby might be affected by the antibodies. This rarely occurs, however, because great care is taken to check for the Rh factor before giving a blood transfusion. The question arises only in those women who may have been transfused many years ago, before anything was known about this factor.

When antibodies are present in the mother's blood, usually after one or more previous pregnancies, these substances pass over to the baby and destroy his red cells, because the antibodies are antagonistic or hostile to them. These antibodies do not endanger the mother, but they may cause severe anemia and other changes in the baby—a condition known as erythroblastosis.

If you have the Rh factor in your red blood cells, you are called Rh positive; if you do not, you are Rh negative. If your husband does have the factor he is Rh positive. Your doctor will check your blood to see if you have antibodies that might affect your baby. This is especially necessary if you either have been previously transfused with Rh positive blood or have had children who are Rh

positive. It is well to have your children checked, because this information will be helpful to your doctor. Also, obviously, you must know the Rh type of your husband.

More attention has been paid to this condition than its frequency and seriousness justify. The truth is that even among Rh negative women who are married to Rh positive men, these antibodies appear in the blood of only about 1 such woman in 20. When they appear, the substances are readily detected in the blood, and certain measures are available to reduce the risks to the baby. Most of these cases are mild problems, and the outlook for the infant is excellent. In the rare, more severe forms, even though the outlook is not as good, the policy of bringing about labor early to cut down on the exposure of the baby to the mother's antibodies, and transfusions for the baby after birth, have led to the saving of many lives.

Rubella

Rubella, commonly known as German measles, if contracted in the early months of pregnancy may harm the unborn baby. Unless a complication occurs, rubella seldom requires treatment. If you have been exposed to the disease, call this to your doctor's attention immediately. Though the baby may appear normal at birth, the doctor will want to examine him regularly for any defects that might become apparent later. Since many babies born of mothers who had rubella during pregnancy are capable of spreading the infection, the doctor will probably recommend isolating the baby.

Chronic diseases

If you have had certain chronic illnesses or disorders before you became pregnant, you may have some difficulty during pregnancy because of them. Such illnesses as diabetes, rheumatic heart disease, chronic kidney disease, tuberculosis, and syphilis may cause special problems.

For a woman with any of these diseases, good care and continuing medical supervision are absolutely necessary during pregnancy. If you have ever had one of these illnesses, you must pay particularly close attention to your doctor's advice and recommendations.

Diabetes, heart disease, and chronic kidney disease may interfere with normal functioning of a mother's internal organs.

Tuberculosis is not inherited by the baby, but after birth a baby may catch this disease from contact with his mother. It is necessary to keep the baby of a mother with active tuberculosis away from her until she is well.

The germ of syphilis can get through the placenta and infect the baby before birth. Some State laws require every pregnant women to have a test for syphilis. Such tests are important because it is possible for a woman to become infected with syphilis without knowing it. Her unborn child may become badly infected if the mother does not receive proper treatment. With early and adequate treatment the chances of having a normal baby are almost 100 percent, but untreated syphilis can cause the death of a baby either before or after birth. If an infected baby lives, it may be physically and sometimes mentally damaged.

Even if the mother has been previously treated for syphilis, the baby can sometimes become infected before birth. Syphilis is a complex disease, and relapse can happen. A woman who has, or has had syphilis, must be followed frequently with blood tests during her pregnancy. She should report to her doctor as early as possible in pregnancy and follow his instruction to the letter, if the baby is to be spared the disease and to develop normally.

The baby's birth

The beginning of labor

Toward the end of your pregnancy, the waiting may seem very tedious. Your doctor will not want you to go far from home alone and you will be limited in what you can do by the awkwardness of your body. But the day does finally come when you pick up the bag you've kept packed in your closet for this occasion, and start for the hospital.

No one knows exactly what sets the birth process off. When the baby is ready to be born, a whole series of events goes in motion.

The first sign you are aware of comes sometime during the last month of your pregnancy. Then you may notice that the baby seems to be settling down, lowering himself in your abdomen. This is called "lightening," and is more apparent with a first child. It means that the baby in the uterus is moving down a little into the bony canal of your pelvis to be in a better position when labor begins. Sometimes this can happen so suddenly that it is startling.

Early contractions

Preparations for labor have been going on for some time. All during pregnancy, the muscles of the uterus have been getting ready to help the baby leave your body. From time to time, they have tightened and let go. This process of growing tight and then relaxing is called a contraction.

These early contractions do not ordinarily cause discomfort. You may not even feel them. Late in your pregnancy, they may be quite strong, coming and going irregularly over a period of several hours or even days. This may be what doctors call "false labor." It is much less common in first than in later pregnancies and is nothing to worry about. In false labor, contractions are chiefly in the abdomen. They do not change much in intensity, the intervals between them are longer and they may be relieved by walking. Sometimes it is hard to tell regular from irregular contractions, so be sure to let your doctor know whenever yours become severe.

Some signs of true labor

You will probably not be in much doubt about what is happening when you are actually in labor. The contractions of the uterus become more and more frequent and intense. You may notice them first as a feeling of pull or tightness in your back that gradually spreads around over your abdomen, or of increased pressure spreading up from the lower part of it. When they come in a steady rhythm, you may be virtually certain that your labor has begun.

At first, these contractions are usually 15 or more minutes apart. The time between them gets shorter and shorter as your labor progresses. They may be perfectly regular or they may come in regular series—10, 8, 7 minutes, then 10,

8, 6, then perhaps 10, 8, 7 again, and so on. They are not affected by changes in your position or activities. If they come during the day, there is no reason not to go on with whatever you are doing, as long as you feel like it. It relaxes some women at this time to watch television, knit, read or do a crossword puzzle. At night, you will probably feel sleepy during the intervals. You may even be able to doze.

During pregnancy, the cervix (see p. 10) softens and relaxes. By the time labor begins it is thin, and has opened to about ½ to ¾ of an inch. Usually a small amount of mucus is present in this opening, as a sort of plug.

As the baby is pushed against the cervix by the strong contractions of the uterus, this opening gradually gets larger until it is finally about four inches wide, big enough for the baby to get through. As the cervix opens, the mucus plug comes loose and passes out, often with a small amount of blood. This usually means that labor is soon to begin.

A sudden rush of water from the vagina means that the bag of waters surrounding the baby has broken. This may happen at the beginning of labor or not until just before the baby is born. Whether it breaks early or later makes very little difference to either you or your child. The time when it breaks has nothing to do with the length of your labor. Your doctor will want you to let him know at once if your bag of waters breaks. It is wise for you to go to bed while someone is getting in touch with him about this.

Duration of labor

Your doctor cannot tell you exactly how long your labor will last. The time differs for every woman and for every pregnancy. Eight to 15 hours after the beginning of labor is an average for first children. Later babies may come more quickly, perhaps in 4 to 8 hours.

Women who have had a good diet and good care during pregnancy tend to have a shorter labor. Some doctors say that prenatal education also helps to cut down the time, especially if this includes exercises properly taught and practiced under competent supervision. Your own attitude has a lot to do with it, too. If you are relaxed, you will find it easier to get some rest between the contractions and your labor may actually be shorter.

Eating and drinking after labor begins

Do not eat any solid food after labor has started. When labor begins, eating may cause nausea and vomiting. Also, a full stomach interferes with a general anesthetic, should you need one. You may drink such liquids as fruit juice, clear soup, black coffee, or tea at any time during the early part of your labor, unless your doctor says otherwise. Water is good to drink at all times unless it nauseates you.

Going to the hospital

You may wonder whether you will have time to get to the hospital after labor begins. If this is your first child, you will ordinarily have plenty of time to call the doctor, the hospital, your husband, a friend, or a taxicab and ride a reasonable distance, after the contractions become regular, before you need help. After the first child, babies usually come more quickly.

You will be glad now if you have made ready in advance: Bag packed and in a convenient place, telephone numbers posted where you can see them at a glance. No matter how well you know them, you may not remember these numbers when you are excited or in a

hurry. But don't start for the hospital until the doctor tells you to.

Admission procedures at the hospital

Perhaps now you will want to re-read pages 36–38 which tell you what happens to you when you get to the hospital. You are taken at once to the admitting office. If there is plenty of time, you are registered here and the information needed for your record is obtained. Then you are taken to the maternity admissions room to be prepared for delivery. In some hospitals, maternity patients are sent here immediately, without a stop at the admitting office. In still others, they are admitted directly to the labor room.

As soon as you have been admitted, you undress and put on a hospital gown. You are checked over by a doctor much as you were on your prenatal visits to your own physician. To protect not only yourself but other mothers, you are observed for signs of a possible infection, such as a cold. A rectal examination is made.

If labor is underway, the hair is shaved from the lower part of your abdomen and from around the vaginal opening. This part of your body is carefully cleansed to prevent infection when the baby is born. You may be given an enema to clean out your rectum and lower bowel. This all makes delivery safer and easier.

When all necessary preparations for your delivery have been made, you settle down in the labor room to stay until it is time for your delivery.

The stages of labor

Labor is divided into three stages. In the first stage, the contractions of the uterus stretch the opening at its lower end, the cervix, so the baby can pass out into the birth canal. In the second stage, the baby passes down through the birth canal and out through the vaginal opening, which also stretches to let him get by. In the third stage, the placenta and membranes (the afterbirth) are loosened and expelled. The first stage is the longest.

During this first stage, the doctor may make several rectal examinations to find out how fast the cervix is opening. By placing his gloved finger in your rectum, he can feel the cervix through the thin wall that separates the vagina from the rectum. On some occasions he may make a vaginal examination with a sterilized glove.

Throughout the early stages of labor, you will have a feeling of "crampiness" in your abdomen and your back may ache. As you come nearer to delivery, you will feel pressure especially in the lower pelvis, and you may have an urge to "bear down" or to move your bowels. This is because the baby's head is pressing on the rectum. Since your bowels were emptied when you were prepared for labor, you could not have a movement now, so don't be concerned about that.

While you are in the labor room someone will be with you or within call all of the time. Your own doctor will check on you as well as one or more of the doctors on the hospital staff. It is becoming more common, in some parts of the country for a husband to stay with his wife in the labor room. This is something the hospital usually decides.

Delivery

Sometime during the second stage of labor, you will be moved to the delivery room. This stage is usually only about 1½ to 2 hours with first babies. The strong muscles of the abdomen and the diaphragm begin to help the muscles of the uterus push the baby out and you have a strong urge to push with each

contraction. Pushing at the right time helps, but if you try to bear down too soon you may tire yourself needlessly. The doctor or nurse will tell you when to do it.

You have probably wondered how a baby can get safely through a channel as narrow as the birth passage. Your body is prepared for this. The bony cavity in the center of your pelvis is normally filled with organs made of very soft tissues: the vagina, the uterus, the rectum, the bladder and the tube from the bladder, the urethra. During pregnancy, the uterus and the bladder are pulled up out of the way into your abdomen. The tissues of other organs become softer and the joints in the pelvic bones become more flexible.

During labor, the vagina stretches enough to let the baby through, pressing the urethra and rectum flat against the walls of the bony cavity. Often the doctor enlarges the exit by making a small cut, called an episiotomy, in the vaginal opening. He does this if he thinks the tissues might tear a little as the baby comes out. This cut heals better than a tear. It is closed with a few stitches after the baby is born. The stitches are made of catgut and do not need to be removed. Neither the cut nor the stitches are painful because the doctor uses either a local or a general anesthetic. You may have some soreness later. An episiotomy is more likely to be necessary with first than with later babies. Some doctors do this routinely because the stitches give the pelvic organs more support.

The afterbirth

The third stage of labor begins when the placenta starts to separate from its attachment to the lining of the uterus. In a short time, usually 5 minutes or less, the muscle wall of the uterus contracts once more and the placenta and the membranes are pushed out. There is usually a moderate amount of blood passed with the afterbirth from the place where the placenta was attached but this bleeding soon becomes slight.

The baby's position

Most babies are born head first. This is the easiest way, for a baby's head is the biggest part of its body and can be molded into a narrow, slightly elongated shape. The effects of this molding disappear in a day or two. It is most marked in firstborns. Some babies come down feet or buttocks first. This is called a breech presentation. A doctor is often able to turn the baby before he is born so that the head will come first.

Medicines to relieve discomfort

If the contractions cause you much distress, you may be given medicine that will make you feel them less. Drugs that do this are called ***analgesics***. Later, when your muscles are being stretched by the actual birth of the baby, you will probably be given some kind of an anesthetic.

An anesthetic, as you probably know, is something that produces complete or partial loss of feeling. There are two principal kinds of anesthesia: ***general*** and ***conduction***. A ***general anesthetic*** makes you unconscious for a short time. Some of them are gases; you breathe them through a mask. Some are given in a solution injected into a vein. ***Conduction anesthesia*** gets its name from the way it works. It interferes with the conduction of nerve impulses to the brain from the place where it is injected. When your nerves are blocked in this way, you have no feeling in the parts of the body with which they connect. But you do not lose consciousness. There are several different types of conduction anesthesia.

Each type of analgesic and anesthesia has certain advantages. Your doctor will

explain these to you, if you ask him, so that you and he may decide together how much pain-relieving medicine, and what kind, you will have. Some mothers want very much to be able to follow what goes on, and to be awake when their babies are born. Others would rather be "knocked out." Knowing how you feel about this will help your doctor to make up his mind about what will be best for you and the baby.

If you have not had much anesthesia you may have the joy of hearing the baby's first cry and of learning, after all these months, whether you have a son or a daughter.

The use of instruments

Once forceps were used only in complicated cases when the baby could not be born naturally. For this reason, many women associated them with trouble, and the idea of a forceps delivery came to be rather generally dreaded. Doctors now frequently use forceps in normal births to lift out the baby's head. This makes delivery easier.

If the time comes when your doctor thinks it will help to use forceps, he will put you to sleep or make your pelvic region numb with a local anesthetic. This is something you definitely do not need to worry about. With careful handling, forceps should not hurt either you or the baby. They may sometimes make a little bruise on the baby's cheek, but this disappears within a few days.

The recovery room

Recovery rooms are becoming common in large hospitals. Some doctors refer to the time spent in them as the fourth stage of labor. This is the room to which you may be moved, after the baby is born, to be cared for until you are fully awake and a little rested. In many hospitals you are left in the delivery room for a while. After an hour or so, you are taken to your own room, perhaps for the first time since you entered the hospital.

In the recovery or delivery room, your blood pressure is taken, you are checked for bleeding and your uterus is gently massaged as it begins to retract. Your own doctor will see you here, if he can. Obstetricians often have to go directly from one case to another. If your doctor is delayed in coming back to you, do not worry. Someone will be with you to give any help you may need.

Your husband may not be allowed to see you until you are back in your own room. The doctor will decide how soon it is best for you to see your baby. Women who are not under a general anesthetic usually see their babies as soon as they are born.

Cesarean Section

Your doctor may have decided that it is advisable for you to have your baby by Cesarean Section. This means that he will bring the baby out through an incision in your abdomen, instead of through the birth canal. Obstetricians perform this operation frequently and with great skill. It almost always turns out well for both mother and child, and may be safely repeated several times. This is a major operation, however, and it will take longer for you to regain your strength afterwards than if you had had your baby in the more usual way. You may have some trouble getting breast feeding started after a Cesarean Section, but, as a rule, the operation itself does not prevent a mother from nursing her baby.

If you have your baby by Cesarean Section, your stay in the hospital may be a bit longer than if you had had a vaginal delivery, because the abdominal wound must heal. Aside from this, your care will be about the same.

Your recovery

Changes in the uterus

As soon as the baby is born, your uterus starts to shrink. Don't be surprised, however, if you still have a "big stomach" for a while. It usually takes about six weeks for the uterus to go down gradually from about 2 pounds to about 2 ounces. Its muscles keep on contracting during this time, as they did during pregnancy. The changing back to normal of the uterus is called involution, which means "the act of turning in."

As the uterus grows smaller, clots of blood and tissue pass out of your body as "lochia." Although this discharge from the vagina is often called menstruation, it is not. At first it comes quite freely, and has a good deal of blood in it. Gradually, it subsides. At the end of the first week it has changed in color from bright red to dark red or brown. At the end of the second week it may be yellow or white, but it is not unusual for the dark discharge to persist for a while longer. It has the odor of menstrual blood.

The contractions of the uterus after delivery are called "afterpains," and are very much like menstrual cramps. They may be more uncomfortable with a second or third baby than with a first one. They usually stop in a few days. You may notice them more if you are breast-feeding your baby, since the sucking of a baby at the breast stimulates the uterus to contract. Even if these afterpains are a little uncomfortable, you will probably not mind since this will mean that your figure is returning to normal.

Getting up

You will probably sleep for most of the first day after your baby is born. Don't try to wake up until you feel like it. You have been working hard for a long time, and will need rest. Your husband will be allowed to see you briefly after you get back to your room. If your pregnancy and delivery have been normal, you are likely to feel fine by the next day. How long you stay in bed depends on the wishes of your doctor and the policy of the hospital. You may be up for a while the first day. Although you may be out of bed soon after delivery, it is best not to try to hurry your recovery at this point, even though you are naturally wondering about what is happening at home. You may drag around for weeks if you don't give your body a fair chance now to get back into its normal, nonpregnant condition.

Eating

After the baby is born, you will probably be extremely hungry. Most doctors let their maternity patients have regular food as soon as they want it. Whatever your previous food habits were, you will have become used, during your pregnancy, to well-balanced meals. Don't

give up these good food habits now. You still need to eat the same foods you ate during pregnancy, plus an extra pint of milk a day and another serving of oranges, grapefruit, or tomatoes, especially if you are breast feeding your baby.

As you begin to be busy again about your home, you will need more protein food in order to keep up your supply of breast milk. Another serving each day of lean meat, eggs, dried beans or dried peas will supply the extra protein you need. For a list of the foods a nursing mother needs every day look again at the last column of table 2 on page 19.

Urination

At the time of delivery, your bladder will be emptied of urine through a tube called a catheter. The nurse will give you a bedpan and suggest that you try to urinate as soon as you are back in bed. After that, you should empty your bladder every six hours at least. It is important not to let it get too full. A full bladder keeps the uterus high in the abdomen and interferes with its contracting. A well-emptied bladder makes it easier for the uterus to get back into its normal position.

Most women have no trouble urinating after delivery. But sometimes, the urethra is pressed so tightly against the pubic bone during the baby's birth that this is bruised. This bruising makes it harder for you to pass urine normally but usually clears up in a few hours. Meanwhile the doctor or nurse may relieve you by catheterizing you again. This is not usually a painful process. Be sure to let the nurse know if there is pain when you urinate.

Going to the bathroom

Usually you are allowed to go to the toilet within 24 hours after your delivery. A nurse or a nurses' aid should go with you on your first trip to the bathroom, just to be sure that everything is all right.

You can help to prevent infection around your vagina by observing a few simple rules of personal hygiene. You will be wearing a sanitary napkin for a few days or perhaps for 2 or 3 weeks Each time you take this off, unfasten the front safety pin first, so that you can let the napkin fall away toward your back without touching you.

After urinating or having a bowel movement, pat yourself clean, going from front to back, not back to front. Don't use a stroking motion. Some doctors insist that their patients use cotton dipped in sterile water for this cleansing instead of toilet tissue. Ask the nurse what the hospital wants you to use if your doctor has not given you directions about this. When you put on a fresh napkin, place the inner (folded in) surface next to you, pin it first in the front and then in the back. Be sure to wash your hands both before and after using the toilet. Tell the nurse if you notice any bleeding that seems to you excessive.

Bathing

You will be told when it is safe for you to take a bath. Most doctors recommend that you wait a week or so. You will probably be permitted to take a shower or sponge bath on the second day. The nurse will show you how to wash your breasts and the perineal area (the region around the vagina). The cleaner you keep yourself, the better you will feel.

Aftercare of episiotomies

Most episiotomies heal soon and cause comparatively little discomfort. Heat applied during the first few days after delivery may be soothing. The nurse will probably bring you a heat lamp, anyway, and suggest that you try it. She will also

show you how to take care of the place where the stitches are. You should continue to follow her directions after you go home until there is no longer any tenderness in the area.

Constipation

Constipation is very common in the first week or two after a baby's birth. If you are constipated, your doctor may prescribe a mild laxative or recommend some changes in your diet. He will certainly advise you not to take strong laxatives. These are bad not only because they tend to cause cramps but because some of their ingredients may get into the milk and give a nursing baby diarrhea.

Your breasts

The production of milk in the breasts is called lactation. True milk does not come for at least 3 days after the birth of a baby. Colostrum, the liquid that comes from the breasts during the first few days, is rich in protein and nourishes the baby until the milk is formed. It also contains substances that protect the baby from certain infections. On about the third day, you will notice that your breasts are becoming tense and firm, the veins standing out clearly. This means that milk is about to begin to flow. Should your breasts be a little painful at this time, a good nursing brassiere will usually make you more comfortable.

Proper support for your breasts is important. Even while you are in bed, you should wear a firm, well-fitting brassiere, preferably one designed for nursing mothers. Sagging breasts are not the result of breast feeding. They are often due to poor support during pregnancy and the nursing period. They may be a family trait.

Wash your breasts once a day with soap and water at the beginning of your bath or shower, using a clean wash cloth for this purpose. If the nipples leak enough to need protection, use the small, sterile pads referred to on page 26.

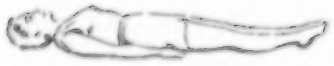
Resuming marital relations

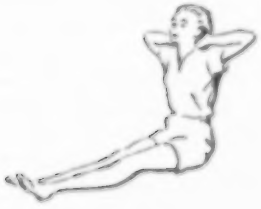
It is usual for husbands and wives to wait for a while after the birth of a baby before resuming marital relations. Advice about this is usually given by doctors on an individual basis. A delay of 3 weeks is commonly suggested but your physician may recommend that you and your husband postpone sexual intercourse until after you have had your first postnatal checkup at 6 weeks.

The return of menstruation

The time when menstruation begins again after delivery is different with different women. Most women have a period within five or six months, anyway. If you breast feed your baby, it usually takes a little longer. In fact, you may not menstruate again until the baby is weaned. If you bottle feed your infant you will probably have a period within five or six weeks. Either way, the first period may be longer or shorter than usual, or the flow may stop and start again. Once menstruation has actually started again, these irregularities usually smooth out and most women are soon back in their old cycles.

Menstruation need not interfere with breast feeding, and you do not need to wean your baby because you have started to menstruate. He may be fussy while you are menstruating. If so, it is probably because your milk supply has decreased enough to make him hungry. You may have heard that as long as you do not menstruate, you cannot become pregnant while you are nursing. This is not true. Whether you nurse your baby or not, the ovaries begin to function again soon after delivery and it is possi-





exercise 1

ble for you to be pregnant before you start to menstruate again.

Exercises

Your doctor may or may not recommend exercises to help you tighten up again after your pregnancy. Some doctors think that special exercises are not necessary if a woman gets out of bed and becomes active within a few days after the birth of her baby. Moving about will certainly help you to get your strength back more quickly. For this and other reasons, it is a good idea to move around as much as possible while you are still in bed. If you learned exercises during your pregnancy to improve your posture and make your body more flexible, your doctor will probably approve of your going on with these now.

exercise 2

The simplest exercises are done lying flat on your back, arms at your sides, with no pillow. One of the easiest is to raise your head from a flat position and try to touch your chest with your chin several times. Another is to try to sit up, after a few days, without bracing yourself, or moving your legs. This may be hard to do at first; if so, try it only once the first day, twice the next day, and so on.

Another good exercise is in two parts. Lie on your back, raise one leg, and bring it up as far as possible without bending the knee or raising your head. Still keeping your back flat, bend your knee, and pull your leg in as close to your body as you can. Try these exercises, first with one leg then the other. Each day try to do them one more time. After a while you will be able to bring both legs up together.

You may be discouraged when you find out how hard it is to do these exercises at first. Take them easily. Do each one slowly until you can repeat it several times without getting tired. Your old energy will not all come back right away. Don't try to hurry the process too much. **Do no exercises at all until you have checked with your doctor.**

In place of or in addition to exercises, your doctor may want you to take what is called the "knee-chest" position for 10 or 15 minutes a day. When you do this, you bend over on the bed or the floor until you are resting your weight on your knees and your chest. When you do this, your uterus flops forward into a better position for drainage.

Visitors

A new baby is exciting to his family and to his parents' friends. Indeed, so many people want to congratulate his mother in person that hospitals have to limit visiting in their maternity wings. You will probably be allowed only two visitors during any one visiting period. Husbands are sometimes allowed some special privileges. As a rule, children under 14 years of age may not visit at all. Visitors are usually able to see your baby through the nursery window during regular visiting hours.

These regulations are for the protection of you and your baby. You need these few days to rest. You need, even more, an opportunity to become acquainted with your new baby, to get the "feel" of his personality, and to begin to learn his language.

Let the people who are taking care of you carry your responsibilities for a while. You will have more to give to your family later if you can relax now in the friendly security of your hospital room, enjoying your husband and your baby but seeing as few other visitors as possible.

Your newborn baby and his needs

Immediate care

The first few hours after your baby's birth are very busy ones for him. His lungs fill with air in order to supply his body tissues with the oxygen they need. If he has any trouble breathing because of mucus in his lungs, throat, or nose, the doctor or nurse will help him get rid of this.

The umbilical cord is cut and clamped or tied off. Some doctors put a dressing on the small piece of cord that remains attached to the baby's navel, some do not. This remnant of cord dries up within a few days and drops off after about a week.

In some hospitals, drops are put in the baby's eyes. The medicine is usually either a 1-percent solution of silver nitrate or penicillin. This is a precaution against certain types of eye infection and is required by law in most States.

While these things are being attended to, the doctor makes a quick examination of the baby and the nurse starts his record by writing down his birth weight, length, sex, and other important facts about his delivery.

Identification

For legal reasons, as well as for your own peace of mind, your baby has some form of identification attached to him before either of you leaves the delivery room. Some hospitals use adhesive tape; others put beads, metal bracelets, or tags on wrists or ankels. Sometimes there are two markers for each baby, exactly alike; the hospital keeps one and the other goes home with the mother. The fingerprints, footprints, and palmprints of your baby may be taken and your fingerprints may be recorded with his as an extra precaution.

Wrapped warmly in a cotton blanket, your baby will be taken from the delivery room to a nursery. If there is any special need for close supervision, he may be placed in a special nursing unit. Wherever he goes, he is given the closest attention and protected in every way from any chance of infection.

Your baby at birth

You may be surprised when you look at your newborn baby for the first time. Chances are that he will seem red, and his hands and feet may appear bluish. He may be wrinkled and scrawny. If he is full-term, his weight will be somewhere between 5½ and 10 pounds. If he is "average," he will weigh between 7 and 8 pounds and be 19 to 22 inches long. He may be covered with a white, creamy substance called vernix (see p. 11) and he may have a lot of fine, soft hair on his scalp.

The baby's head may be a bit out of shape, at first, because of the molding it received during birth. Don't let this bother you. The bones of his head are soft and flexible, with spaces in between called fontanels. The soft place between the bones on top of his head is one of these. Because of these spaces, the head of a child about to be born can be safely compressed quite a little as it goes through the birth canal. It will usually go back into proper shape within a few days.

All newborn babies have arms and legs that seem much too small for the size of their heads. They wave their arms wildly about and kick aimlessly with their tiny bowed legs. Your baby's eyelashes and eyebrows will be so fine you can hardly see them. He will not be able to focus his eyes. He will cry without tears, for his tear glands are not yet working. He will not know how to smile or respond to you in any other ways. He will want to sleep most of the time.

Most little babies cry when they are hungry. Some cry when they are wet or otherwise uncomfortable; some do not. Some cry more than others. Most of them seem to get a lot of comfort from being held and cuddled, rocked and sung to. It is so natural to give babies this kind of attention that you may be tempted to pick yours up more often than is necessary after you get him home. During most of the day, newborns need to sleep quietly in their bassinets. You will probably be handling yours enough, at first, if you play with him only when you pick him up to feed him, change his diapers, or put on his outdoor clothes.

Some babies seem to be more comfortable in the first few weeks if they are snugly wrapped in a small thin cotton blanket. If this is the procedure in your hospital, the nurse will show you how to fold the blanket around the baby so that the wrapping stays in place and is not too tight.

Whether your baby is rooming with you or is in a nursery for newborns, you will be surprised to find out how much you can learn about him and his care during the few days you are in the hospital.

Feeding your baby

Your baby is brought to you for his first meal sometime between 12 and 24 hours after birth. Whether you plan to breast or bottle feed him, you will need to help him learn how to use a nipple.

How your baby gets his nourishment will depend on a number of things—your ability to produce a good supply of milk, your health, your way of living, your preferences for breast or bottle feeding. Breast milk is a natural food. It has in it most of the food elements a newborn baby needs for growth, combined in ways that make it easy for him to use them. Even if you cannot continue nursing, it is good to start your baby at the breast because of the benefit he gets from the colostrum. (See p. 67.)

Many mothers want very much to nurse their babies, and get great satisfaction from doing so. If you prefer to bottle feed your baby you have every right to make this decision and be happy with it. As yet, there is no proof that breast feeding is always better for children than bottle feeding. Either method can be good for your baby under the right conditions. Breast feeding does have the advantage of immunizing a baby against certain infectious diseases through the action of the antibodies he gets in his mother's milk.

One of the important reasons for breast feeding is the contact with his mother's arms and body, the feeling of warmth, closeness and security a baby gets from being held while he takes his food. Your bottle fed baby can have this security if you hold him in your arms to feed him just as you would do if you were offering him your breast.

During early breast feedings, the nurse will help you show the baby how to get your milk. He is born knowing how to suck but he needs help in finding the nipple. He roots around for this, and will find it, if it is anywhere near his mouth. Let his cheek touch your breast. Then, when he does find the nipple, see that he gets his mouth completely over it and over the darkened circle around it, the aureola. Hold the top of your breast away from his nose with the tip of one finger, so that he can breathe easily.

Some babies want to be put to the breast frequently during the first few days, at fairly short intervals. This seems to help the milk to come in. While the milk is forming, let the baby suck a short time on each breast; ten good sucks on each one may be enough at first. After the milk begins to flow, a baby will suck longer. The breast you start with is usually the one that is most thoroughly emptied. For this reason, it is customary to begin each feeding with the breast you gave second the last time you nursed. If you do this, each breast is emptied regularly every 8 hours or so, but is also stimulated at each feeding. It is this frequent stimulation that increases the milk supply to give the baby more and more milk as he grows older.

A baby usually learns to suck well from the breast within the first few days, although some need more time. He will do better at it if he is hungry. For this reason, the only supplementary nourishment most babies get while they are learning to nurse is boiled water cooled to room temperature.

There are so many individual differences in the nursing behavior of infants that you will have to find out for yourself how your baby likes to take his food. You and he have to get used to each other. If you particularly want to nurse him, don't give up too soon. You probably will not be able to tell before you leave the hospital whether or not you are going to have enough milk for him. Completely satisfactory nursing is often not established until late in the second week.

Once breast feeding is going well, the usual total nursing time at any one feeding is 15 to 20 minutes. The baby may get all the milk he is going to drink in 8 or 10 minutes but he will suck for several minutes longer. He needs the satisfaction he gets from sucking just as much as he needs the milk he drinks, although for different reasons.

As a baby drinks, bubbles form in his stomach. This is a normal part of his digestion, but it can make him uncomfortable. That is why you need to "burp" him. Hold him up against your shoulder or ask the nurse to do so, then pat his back gently, so he can bring his bubbles up. Another way of "burping" is to sit him in your lap, his stomach resting against your forearm. With the other hand, you can stroke upward on his back to help him push the air out of his stomach. In either case, protect your dress with a soft cloth, in case he spits up more than air or gas bubbles.

If your nipples are unusually tender, your doctor may advise you to put something on them between feedings. Be sure to wash this off before you put the baby to your breast again. The doctor may also suggest that when you are not nursing, you protect your nipples with a clean pad of gauze or soft cotton cloth, using a cream if necessary.

After the milk has started, it will continue to form as the baby sucks. On the other hand, if you are not nursing your baby, your milk supply will not be needed and will gradually dry up. Your doctor will tell you what, if anything, to do about this.

Bottle feeding can be a very satisfying experience for you and your baby if you do it in a way that is comfortable for both of you. Hold the baby in your arms when you feed him, so that he feels the warmth and closeness of your body as

a comfortable bottle feeding

he sucks. It is better, for several reasons, not to prop the bottle in the crib; while he is eating, your newborn needs all of your love and attention.

Tilt the bottle so that the neck of it is always full of milk when the baby is sucking. This prevents air bubbles from getting into the milk. Check frequently on the size of the holes in the nipples. If the holes are too big, the flow of milk will be more than the baby can manage. If they are too small, he will not get enough milk and will have to work too hard for what does come through. In the Children's Bureau pamphlet ***Infant Care,*** you will find much more information and many more suggestions about baby feeding than can be given here. This booklet can help you in many ways even before your baby is born. You can easily obtain a copy by sending 20 cents to the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Whether you breast or bottle feed your baby, you will have to work out a timetable for his meals that suits you both. There are no hard and fast rules about this. The time between feedings may depend upon several things: the size and weight of the baby, how often he seems to need food, and whether you and your doctor want to try letting him make his own schedule. A cry you will soon learn to recognize will be his way of telling you when he is hungry. At first, his signals may come at irregular intervals but he will probably soon fall into a rhythm of his own on which he will thrive.

To feed your baby, take a position that is relaxing. If you are up, sit in a comfortable chair. Don't perch on the edge of the bed. As a precaution against possible infection, wash your hands thoroughly with soap and water and be sure that your nails are clean.

The baby's bath

Most hospitals no longer give sponge baths with soap and water to new babies. In fact, your baby may not be bathed at all for several days, although the folds of his skin may be cleansed with mineral or baby oil on cotton balls. Surgical gauze is not used for sponging the skin of a newborn. It is rough in texture and apt to be irritating.

Most babies get their first real baths on the seventh or eighth day. Tub baths are delayed until the stump of the cord has fallen off and the navel is healed. Whenever the diaper is changed, the region around the genitals and buttocks should be carefully cleaned with baby oil or warm water and mild soap. Your baby's skin may become dry and scaly, but this is nothing to worry about. It is a condition that usually corrects itself as the baby gets older.

Clothing for the newborn

Nowadays most babies start off with a minimum of clothing (see p. 41).

When yours is brought to you in the hospital he will probably be wearing only a diaper and little cotton shirt and perhaps a short gown. He will be wrapped loosely in a soft, warm blanket. This is about all the clothing he will need indoors for several weeks.

Babies do not like to be either too warm or too cold. They will fuss if their clothing is too heavy, too hot or too tight. They need to be able to move their bodies freely, especially their arms and legs. You will not need to cover your baby's head, unless you are taking him outdoors on a cool or windy day. A padding around the sides of his bassinet, carriage or crib will usually be enough to keep off a draft.

Circumcision

If your baby is a boy and is to be circumcised while you are still in the hospital, you will be asked to sign a permission slip for this. It is a very common and very simple operation. What the doctor does is to remove part of the fold of skin (the foreskin or prepuce) that covers the tip of the penis. When this is too large or too tight, it interferes with urination and personal cleanliness.

Babies who need it are usually circumcised before the second week of life, preferably within the first four days. This may be done in the delivery room at birth, with the parents' consent. It is often more convenient and more economical to have the operation take place then, and there is the added advantage of having the baby under hospital supervision for a day or two afterwards. The wound is small, heals in a few days and does not usually require any special care after you go home. A little petroleum jelly will keep the diaper from sticking to it.

If your baby is to be circumcised for religious reasons, there will be more formality. Find out what the ritual is, if you do not already know, so that you can make the necessary arrangements with the hospital and the doctor.

The first few days

Tiny babies need to be protected against infection. This is why hospitals take every possible precaution to keep newborns away from people with colds, sore throats, intestinal upsets, or skin infections. If the baby is born at home, try to be just as careful.

Most new babies lose weight at first and may not begin to regain it until they are about a week old. This weight loss is due to loss of water from their bodies, to the passing of materials that gather in their intestines before they are born and to lack of nourishment during the first two or three days of life. If your baby does not begin to gain by the end of the first week, let your doctor know.

You may notice that your baby's breasts get a little red and seem to grow bigger the first few days. Drops of milk may even ooze out of the tiny nipples. This can happen with either a boy or a girl, but is not very common. It just means that some of the internal substances that were getting your breasts ready for nursing also passed into the baby's body from your blood before he was born. As these substances are carried off, the swelling will subside. Be careful not to press or rub the baby's breasts while they are in this condition.

If yours is a girl baby, a few drops of blood may come from the vagina for a few days after birth. This bleeding is usually caused in much the same way as the breast enlargement. It will disappear shortly.

Care of premature babies

If your baby weighs less than 5½ pounds when he is born, he is considered

premature. His body is not quite ready to adjust to life in the outside world so he is placed in an incubator, if this is necessary. Temperature and humidity are carefully controlled in the incubator and extra oxygen is supplied if needed. Special precautions are taken to keep infection away from the baby when he is fed or changed. This is why you may not be able to have him with you while you are in the hospital.

Although your premature baby may not be strong enough to nurse for a while the doctor may want your milk for him. In that case, the nurse will show you how to express it by hand or with a breast pump, so that it can be fed to the baby. Doing this helps to keep up the milk supply, an important consideration if you are going to try to breast feed your baby when you get him home.

The kind of care a small premature baby needs can usually be given only in a hospital. If yours, by any chance, is born at home, make every effort to get him at once to a hospital that has a staff trained to look after premature babies and equipment for their care. Your doctor or a public health nurse will help you make the arrangements. In an emergency, the police will help you get transportation.

How long a premature infant stays in the hospital depends on his progress. A baby who weighs almost 5½ pounds at birth may need very little special care. The smaller ones are usually kept in the hospital until they weigh at least 5 pounds and show in other ways that they are strong enough to get along without hospital care.

The public health nurse who visits in your neighborhood will know about the birth of your premature baby, and will help you get ready for his return from the hospital. After he comes home, she will visit you from time to time. She can help you in a number of ways to carry out your doctor's recommendations for his care. He will not be returned to you until he is sturdy enough to be at home.

The baby's name

It may save much trouble later if your baby's name can be entered on the original birth certificate. Try to decide upon it before you go to the hospital. Since you will not know in advance whether you are going to have a boy or a girl, it is a good idea to have names in mind for either one. If a name cannot be entered when your baby's birth is first registered, be sure that it is added to the official record later.

The birth certificate

A birth certificate, properly filled out and filed, is the legal record of your child's birth and will be recognized as such in any court of law. One of the most important things you have to do before you leave the hospital is to make sure that your baby's birth certificate has been completed and sent to the proper authorities.

You probably know from experience how often your child will need this proof of his identity during his life. He will use it as proof of age when he enters school, when he applies for his first work permit and his first driver's license. He may have to have it to prove his right to vote, to marry, to draw social security benefits, to hold certain kinds of jobs. It can help to settle insurance claims, and questions of parentage, inheritance and citizenship. Without a birth certificate, for example, it is hard to get a passport for travel in foreign countries.

The hospital will take the main responsibility for seeing that your baby's birth certificate is completed and sent to the registrar of births in your com-

munity. If a baby is not born in a hospital, the doctor or midwife in attendance is responsible for making out the certificate and filing it with the registrar.

If there is time when you are admitted, the hospital will get from you then the information that has to go on the certificate: the names, addresses, ages, and occupations of you and your husband. If this information is not obtained when you enter, a nurse will get it from you later. The date and other necessary facts about the baby's birth are added by the hospital or the doctor after the child is born. The certificate must be signed by the doctor and the hospital superintendent.

The local registrar will be the local health officer or someone on his staff. When he receives the birth certificate he goes over it very carefully for mistakes and if necessary sends it back for corrections. When everything is in order, he makes a copy for his own files and sends the original to the State office of vital statistics, which is a part of the State health department in most States and is usually located in the State capital.

You will be officially notified when the record of your baby's birth is on file. In some States, this notice will be mailed by the local registrar; in others by the State office. It may be a photostat of the original, except for the medical information; or it may be a short form containing only the baby's name, date and place of birth and his parents' names. If your baby's certificate is in any way incorrect, see that it is corrected immediately. In some States, the birth certificate is sent only on request and for a fee. There is practically always a charge for second copies. The personal information on all birth certificates is confidential.

Getting to know your baby

Although your stay in the hospital will probably be short, these few days have a lot to offer you and your family. During this time, you will be with people who are especially prepared to help you with your own after care and the care of the baby. You will be protected from having to do too much too soon. Above all, you will have a chance to get to know your new baby in a quiet and peaceful atmosphere.

This last point is in some ways the most important. At first, you may not feel the outpouring of love for your new baby that you expected. You may be disappointed because he isn't as pretty as you thought he would be, or because he doesn't respond to you when you first talk to him or fondle him. His first attempts to nurse may be uncomfortable for you. You may be afraid of him because he is so small and fragile looking.

As a rule, none of these feelings mean much in the long run. The babies who are homeliest at birth are often the prettiest later. Gradually they "wake up" and begin to notice the people who look after them. The nursing smooths out and the little bodies become sturdy. Mothers and babies have to learn to know and enjoy each other, and this takes time. Love will grow between you and your baby as you make him comfortable and he begins to show signs of personality in his own special ways.

Your family doctor or your pediatrician will be getting to know your child at the same time you are. While you are in the hospital, he and the nurses can be of much help to you in this "getting to know you, getting to like you," process.

Your homecoming

Leaving the hospital

Leaving the hospital after you have had a baby is not an ordinary homecoming. You have been through a special experience that has made unusual demands on you, physically and emotionally. Now the baby is safely here, but with considerable final effort on your part.

Since the baby's birth, you have been a center of concern and attention. Other people have watched over you, cared for you, and made decisions for you. Soon you are going to be on your own again, looking after your family and gradually resuming your normal social activities. With a difference! There is another person in your family now, someone who is going to need a great deal of attention for some time. It will take a little while for you to settle down to the changes in your routines. It will also take a while for you to feel like your old self again. This will be true whether your baby was born in a hospital or at home.

Your first days at home will be easier if you plan for them as carefully as you planned for your pregnancy and confinement. At the time you enter the hospital, no one can tell you exactly when you will be leaving. For this reason, don't plan to be out on a certain day. When it is time for you to go home, your doctor will notify the hospital and sign the order for your discharge.

The usual hospital checkout time is between 11 a.m. and 1 p.m. A hospital discharge takes a little while and whoever comes for you should be free to wait, perhaps as much as an hour, while you are going through the formalities.

On the day before you leave, have someone bring you the clothes you want to wear home and the things you packed earlier for the baby. Choose a dress or suit that has been a little big for you. You may not be able to wear all of your regular clothes right away because your measurements are apt to be larger than they were before you became pregnant. It is a good idea to wait until after the baby's last feeding to put on your street clothes.

You will probably have some business papers—such as insurance policies and form letters to employers—which need to be signed by the hospital authorities. Ask the nurse, a nurses' aid, or a messenger to take them to the proper office for signature. Do this well in advance of your departure, so that you will not be waiting impatiently at the last minute for the documents to come back. The valuables you put in the hospital safe will be returned to you when you pay your bill.

If your baby is on a bottle, the hospital may send a 24-hour supply of the formula home with you with directions for preparing and using it. Some hospitals ask you to provide the bottles for this. If you have prescriptions, you may be able to have these filled at the hospital pharmacy. This is easier than having to send

to the drugstore after you get home.

Before you leave, the nurse may go over with you the instructions you have been given for your own and the baby's care. Find out now when your baby should have his next checkup and where you are to take him for this. There will be other appointments for him, and it is very important for you to keep them if you possibly can. One of the best ways to keep well children well is to see that they have the periodic health examinations recommended for them. If you do not have a pediatrician, your family doctor may look after your baby himself or he may advise you to take him to a child health conference or well-baby clinic.

Help for you at home

It will mean a great deal to both you and your husband if someone comes in to help you when you first return from the hospital. You will be tired and may not feel like doing much about the house for several weeks.

Your doctor will probably advise you to rest in bed as much as you can for the first two weeks. He may suggest that you get up only three times a day at first, for an hour at a time. Gradually you can increase the time you are up until, toward the end of the second week, you are out of bed most of the day. On a schedule like this you can care for the baby, begin to do things for the other children, and still gain strength.

Some mothers have to take hold immediately, of course. Unless you must, it is better for you not to try to do housework for at least two weeks. Some fathers take over some household duties as a matter of course when their babies are born. This is a good example of husband-wife partnership. Other relatives and friends are often glad to help out. It will be a relief to know that you can depend on someone, if only to get the evening meal.

If you can have the services of a homemaker (see p. 39), a part-time maid, or a babysitter, by all means arrange for this assistance. You will be wise to take full advantage of any commercial services that are available to you, especially diaper services and laundromats. The more of the washing you can get done out of the house, the better. This goes for the cooking too. If you live near a good carryout restaurant, you may be able to save considerable time and energy by sending out for a main supper dish once or twice a week.

In some communities, young couples have formed clubs to help each other out at times like this. While a mother is in the hospital having her baby, other mothers in the group keep in touch with her family, substituting for her in emergencies. When she is ready to come home, someone sees that there is enough food in the refrigerator for the first two or three meals. After the new mother has been at home for a few days, someone calls to ask if she needs any shopping done. When she is strong enough to go out, mothers in the club take turns babysitting so that she and her husband may begin to do things together again. If you do not have such a group in your neighborhood, your church may be interested in helping you start one.

Planning with the family

It will be much easier for you to manage after you bring the baby home if the whole family pitches in to help. The best way to get this kind of cooperation is for you all to talk the situation over together before you go to the hospital. This gives everyone a chance to get the whole picture, see how he fits into it, and help work out a plan for getting things done that will meet all foreseeable needs.

There are no fixed rules for sharing family responsibilities. What the children can do will depend on their ages,

teamwork

skills, and temperaments. You and your husband have formed habits of working together in certain ways and it may not suit either of you to change these now. Two suggestions, however: Fathers cannot really get to know their babies unless they can spend some time with them and do some of the holding, comforting and feeding. Also, neither parent needs to be constantly exhausted from lack of sleep. If you and the baby's father take turns looking after him at night, the one who is "off duty" can learn to sleep through. To make up for sleep lost at night, if any, you may be able to take naps in the daytime while the baby sleeps.

Your postnatal care

Before you left the hospital, your doctor may have checked you over to make sure that your pelvic organs were returning to normal. About 6 to 8 weeks after your delivery, he may want to do a more complete internal examination to see if the uterus has gone back properly to its normal, nonpregnant position and size. This checkup is called a post partum examination. If you want advice about spacing your future pregnancies in any manner which is in accordance with your religious beliefs, this is the time to ask your physician for it.

It is very important for you to follow directions or suggestions your doctor gives you about your personal hygiene after delivery. Ask him when to use douches and tampons again. You may be uncomfortable if you do this too soon, because it takes about six weeks for the place where the placenta was attached to the uterus to heal. You will also have some discomfort, and run some risk of infection if you and your husband resume marital relations sooner than three weeks after the baby has been delivered. This is partly a personal matter but there are health factors involved. You and your husband may wish to discuss this question with your doctor.

Before you start driving your car or going up and down stairs as usual, it is advisable to check with your physician. In general, you can begin to do what

you want to do as you feel equal to making the effort.

Backaches bother some mothers after childbirth. Plan your work so that you do not bend over any more than is absolutely necessary. Sit down as much as you can when you are taking care of the baby. When you can't sit, work at a counter or table of comfortable standing height. Sometimes it helps to wear a well-fitted corset for a while. Your doctor will suggest this if he thinks it is necessary.

Your doctor may want you to continue your exercises for several weeks. (See p. 68.) The ones you do now will be more vigorous than the ones you may have learned in the hospital. Find out just what exercises you are supposed to take and practice them faithfully. They are designed to recondition the parts of your body that were especially relaxed when your baby was born.

Take a shower or sponge bath every day at first and then a tub bath when you feel like it. You will normally perspire freely at this time. An underarm deodorant after your bath will make you feel fresher.

To keep your bowels moving properly, drink plenty of water, take a sensible amount of exercise, eat foods that tend to prevent constipation, and try to have your bowel movements at regular times (see p. 50). If you need a laxative, ask your doctor to prescribe one. The wrong one may affect your breast milk.

Even though you went to see him while you were pregnant, go to your dentist again six or eight weeks after your confinement.

Should you feel depressed after the baby comes, don't be surprised or discouraged. This is a very common reaction. Doctors call it the "baby blues." Sometimes it does not come right away. Fortunately the feeling is usually a passing one. If it should persist, you will want to discuss it with your doctor. It should disappear as your strength returns and you begin to do things that give you a new sense of purpose and enjoyment.

Caring for your baby

The mother of a new first baby often wants very much to take care of her own child but is persuaded to let someone else "more experienced" do this for her. If you want to care for your baby, do it, no matter how much you think you have to learn. No two babies are ever exactly alike and every mother has to find out how to apply what she has been taught to meet the needs of her own particular child. Reading may help. There are many excellent books and pamphlets on the market about babies. Your doctor, the visiting nurse, the nurse at the well-baby clinic, or your librarian can give you the names of several.

In this bulletin we cannot go deeply into the details of infant care. There are some things we can say here, however, that may give you more confidence in your own ability to look after your new baby. Whether he is being fed on a schedule or at his own demand, be consistently prompt with the feedings. After feeding him, put him gently back in his crib. Some babies can return a meal as easily as they took it in if they are jolted or jounced too much. Don't fuss over him and never wake him up just to show him off. Don't worry if he snorts and sometimes breathes noisily or irregularly in his sleep. Little babies normally make some very odd noises. They can also breathe so quietly that you sometimes wonder if they are breathing at all.

A little baby should not be startled unnecessarily. When you pick him up, move slowly, putting your hand under his back as you lift him so that his back, neck, and head are supported. Don't pick him up by his arms. These are not yet strong enough to bear the weight of his body.

firm and loving support

Each time you put him down after feeding, bathing, or diapering, shift him a little. He can't turn over by himself and he gets tired if he lies too long in one position. It will be several weeks before he can hold up his own head and several months before he will be able to sit up by himself. It is good for a newborn baby to lie on his side but he needs support for this. A rolled-up blanket or several tightly folded diapers can be propped behind him.

Be sure he is comfortable but don't watch over him too closely. Babies get along surprisingly well when they are treated like regular people. As long as yours sleeps peacefully, eats contentedly, gains weight regularly, and has a skin that is warm, moist, and healthily pink, you do not need to be anxious about him.

Many mothers are afraid that they will not understand what their babies are trying to say when they cry. Your baby will soon have several different cries and you will learn to know what each one means. He will cry to let you know when he is hungry, when he is sleepy, when he is uncomfortable, when he is lonely, and when he is in pain. You will not "spoil" him if you give him what he is asking for. His wants at this age are ***needs***—needs for food, for sleep, for comforting, for the reassurance he gets from close and loving contact with your body. Do not be afraid to satisfy these needs. He will soon learn to use his cry as a signal and wait for you to come to his aid. It is only later that he will begin to want things that may not be good for him. Then you will have to say "No."

Learning more about parenthood

What parent education is

Is there a course for expectant parents in your community? Your doctor or your public health department will know. If there is, your physician will be glad to tell you whether or not he thinks it would be advisable for you and your husband to join it. Some of these are for mothers, some for fathers, and some for both together. You and your husband have final responsibility for making your own plans and decisions about rearing your children. But you want to be sure that your reasons for making these plans and decisions are as good as they can be.

The idea of education for pregnancy, childbirth and the care of babies may be new to you. But haven't you been "shopping" for information ever since your pregnancy began? You have questioned your doctor, his nurse. You have talked with relatives, neighbors and friends. You have read some of the materials prepared for expectant parents by magazine writers, newspaper columnists, manufacturers of clothing, food, furniture and equipment. You have watched television commercials and listened to radio programs about prenatal care.

The difficulty is that, except for what we learn from doctors, nurses, and other professionally trained people, most of us have no way of knowing how reliable the information is that we get from these different sources. This is why courses and classes for expectant parents are becoming more and more popular in many parts of our country.

These programs are carried on by a number of different agencies and organizations. To be acceptable, they must have the approval of local medical authorities. Among the usual sponsors are State and local health departments, visiting nurse associations, the American Red Cross, hospitals, maternity centers, churches, public schools, family service associations. When there are fees for tuition, these are almost always small and are often waived. The leaders are usually public health or maternity nurses who have had some special preparation for working with groups.

Most of these courses or classes are conducted informally. When you register you are usually asked to fill out a card, giving a few facts about yourself and your family. It helps the teacher to know where you live, who your doctor is, whether this is your first child, and when you expect your baby.

Subjects studied

Classes for expectant parents cover a wide range of subjects. These include more or less the same topics discussed in this pamphlet. But group members have opportunities to suggest other topics for discussion or to ask questions they would like to have answered. The leader may

class for expectant parents

build up the whole program on these interests or may list them for future reference and bring them up where they seem to fit best in the program. In some classes exercises are taught as part of the preparation for childbearing.

Methods of teaching

The teaching methods used are varied and interesting. In some groups, the meetings are based on group discussion carried on from session to session. Other classes follow different plans. On one evening, a group may enjoy a lecture followed by lively discussion. At the next meeting, members may look at a film, study slides, or put on a skit. Often there will be demonstrations and opportunities to practice certain skills, such as bathing a baby. Always, there will be time for additional questions and the exchange of ideas.

Some values

A good experience with a group like this has many advantages. Husbands and wives who may have been a little shy with each other about the pregnancy frequently learn to talk things over together more freely. The facts they learn about human growth and development help them to understand themselves better and to be more realistic in their expectations for their children. Both feel

more comfortable about what they are learning because they are learning it together. A father who came late into one of these groups said, gratefully, to the teacher after a meeting, "These classes turned a light on for my wife. I felt that I was in a dark room. Now the light's beginning to come on for me, too."

In these informal discussions, people sometimes feel free, for the first time, to talk about their fears. The anxieties of pregnancy are so common that anything you are worrying about is probably bothering at least one other person in the room. It helps a lot to know that other parents have feelings and problems like yours. Indeed, it often happens that some fears disappear altogether after a good airing. This does not mean, of course, that people are encouraged to bring up their serious personal problems in these meetings. These they are advised to discuss with their doctors.

These courses have other values, too. Parents who become interested in them often go on to take advantage of other educational opportunities in their communities. A father may discover that he would like to try his hand at making baby furniture. The chances are that someone in the group will be able to tell him about evening courses in carpentry in the adult education program of the public schools. Someone else may know of a cabinetmaking project at the Y. A mother may learn about a new babysitting service, or hear of a sewing class that specializes in the making of maternity and baby clothes.

Just to come out and be with people is a value itself.

You will be fortunate if there is, within reasonable distance of your home, a group for expectant parents that meets your needs and interests. You and your husband are starting out, perhaps for the first time, with a brand new baby. Both of you have no doubt already said to yourselves many times, "I wish I knew—." The chief purpose of prenatal education, in all of its many forms, is to help mothers and fathers ask the right questions and look in the right places for the answers. The more you and your husband know about your needs and your baby's the more meaning your parenthood will have for you, and the more you will be able to do to give your child a good, firm start on the road to a healthy, happy adult life.

Appendix

Birth of the baby without medical attendance

Sometimes a baby is born before the doctor arrives, or before the mother can leave home to get to the hospital. This emergency is unusual, and is not as likely with a first baby as it is with later babies.

If you are faced with this problem, try not to feel frightened. When a baby is born so quickly that you cannot get the doctor in time, it nearly always means the birth is very normal. You would probably have had time to get the doctor, or to get to the hospital if the birth was going to be difficult.

Certain things can be done which will make it easier for both you and the baby. You cannot do these yourself. So get someone to stay with you until the doctor comes.

Instructions to the helper

1. Be sure the doctor or ambulance has been called.
2. See that the mother is comfortably lying down.
3. Wash your hands thoroughly.
4. Do not touch the area around the vaginal entrance.
5. Place a clean towel under the mother's hips for the baby to come on to. If you have time, protect the bed with newspapers.
6. Let the baby come naturally.
7. If the bag of waters has not broken, and the baby is born still inside the sac, puncture the sac with a pin or tip of scissors. Wipe the sac and fluid away from his face and head with the inside of a clean handkerchief.
8. As soon as he is born, wipe the baby's mouth, nose, and face with the inside of a clean handkerchief. Do not use cotton or paper tissues.
9. Move him carefully to a clean spot between the mother's legs, with his head elevated a little and away from any fluid or secretions. ***Do not stretch the cord.*** Let it remain a little slack.
10. If the doctor has been called and is on his way, you do not need to tie the baby's cord. Leave it attached. Leave the baby in a clean spot between the mother's legs, but cover his body with a blanket or towel to prevent chilling. Leave his head uncovered so he can breathe.
11. If you have not been able to reach the doctor, or if he cannot get there within an hour, the cord should be tied.
    (*a*) Tie the cord ***tightly*** in two places about 2 inches apart with clean pieces of tape or strong twine. The tie nearest the baby should be about 6 inches from his navel.
    (*b*) Cut the cord ***between*** the two ties with a clean pair of scissors.

(*c*) Wrap the baby in a clean flannel square or blanket, with his face uncovered, and lay him on his side in a warm place.

12. Let the afterbirth come by itself. ***Do not pull on the cord to make it come out.*** Save the afterbirth in a basin or newspaper for the doctor to examine.
13. As soon as the afterbirth has passed out, place your hands over the mother's uterus (a firm lump just below the mother's navel).
14. Cup your hands around the mother's uterus and massage the uterus several times to keep it firm. If it does not stay firm, hold your hands around it until it does.
15. Clean the mother's buttocks and lower thighs, but do not touch the area around the vaginal entrance.
16. Make the mother comfortable and see that the baby is warm and breathing. Give the mother a hot drink, such as tea, if she wishes.
17. Do not leave the mother until the doctor comes.

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